Minutes of the special meeting of the Board of Directors of the Cook County Health and Hospitals System held Friday, September 18, 2009 at the hour of 9:00 A.M. at John H. Stroger, Jr. Hospital of Cook County, 1901 W. Harrison Street, in the fifth floor conference room, Chicago, Illinois.

I. Attendance/Call to Order

Chairman Batts called the meeting to order at 9:20 A.M.

Present: Chairman Warren L. Batts and Directors David A. Ansell, MD, MPH; Hon. Jerry Butler; David Carvalho; Quin R. Golden; Benn Greenspan, PhD, MPH, FACHE; Sister Sheila Lyne, RSM; Luis Muñoz, MD, MPH; Heather E. O'Donnell, JD, LLM; and Andrea Zopp (10)

Absent: Vice Chairman Ramirez (1)

Additional attendees and/or presenters were:

John Abendshien	Randall Johnston	John Raba, MD
Michael Ayres	Michael Koetting	Elizabeth Reidy
Patrick T. Driscoll, Jr.	Roz Lennon	Deborah Santana
Sylvia Edwards	John Morales	Anthony J. Tedeschi, MD, MPH, MBA
William T. Foley	Jeff McCutchan	
Jeanene Johnson	Mayur Patel	

II. Public Speakers

Chairman Batts asked the Secretary to call upon the registered speakers.

The Secretary called upon the following registered public speaker:

1. George Blakemore — Concerned Citizen
2. Deborah Threlkeld — Caseworker, John H. Stroger, Jr. Hospital of Cook County

III. Discussion/Information Items

A. Strategic Planning: Board Progress Meeting and Discussion

- i. Opening and Introductions
- ii. Process Overview and Progress Update
- iii. Current State
  - a. Market Characteristics
  - b. CCHHS Overview
- iv. Financial Planning Update
  - a. Forecasted Sources and Uses of Cash, FY 10-12 baseline
  - b. Key Initiative Modeling Update
  - c. Entity-Specific Score Card
- v. BREAK
- vi. Feedback and Next Steps
- vii. Interview/Focus Group Feedback

III. Discussion/Information Items (continued)

viii. Town Hall Meeting Input

ix. Discussion: Core Themes and Design Principles

x. Next Steps

Mr. Foley provided an overview of the meeting's agenda and explained the purpose of the meeting. He stated that this meeting is to prepare the Board for the October 7th retreat. He then introduced John Abendshien from Integrated Clinical Solutions, Inc.

Mr. Abendshien introduced his team and proceeded with the presentation (Attachment #1).

The Board reviewed and discussed the information.

One issue discussed was the provision of long-term care at Oak Forest Hospital of Cook County. Questions were raised with regard to community needs and the reason why the System outsources these services. Randall Mark, Director of Policy Analysis for the System, provided background information relating to when these services were outsourced in 2007; a cost analysis done at the time indicated that outsourcing would be more economical. Sylvia Edwards, Chief Operating Officer of Oak Forest Hospital of Cook County, added that Oak Forest Hospital's services for long-term care were based upon a hospital model, which is what drove the costs up.

The Board discussed capital planning issues. Mr. Foley stated that he has recently met with the County's Department of Facilities Management and Office of Capital Planning and Policy regarding the old Cook County Hospital Building. Additionally, he addressed two major capital priorities – Stroger Campus parking and the Fantus Clinic.

Director Zopp inquired whether the System must go through the County for capital needs if they find the funding for the projects themselves. John Morales, Chief Financial Officer of John H. Stroger, Jr. Hospital of Cook County, responded that the County's Office of Capital Planning and Policy manages these projects because they have the engineers, etc. on staff, and historically, the long-term bond money has been controlled by Capital Planning. He stated that it wouldn't be impossible for the System to break off and manage their own projects, however, there would need to be an infrastructure in place at the System in order to manage these projects. He added that it may be possible to meet with the Cook County Board to address the possibility of the System getting moved up in the order of priority for capital projects.

The Board concluded by discussing key questions on major strategic issues. Mr. Abendshien stated that this information would be helpful in preparing for the October 7th retreat, at which the Board will have an extended discussion period on the subject.

IV. Adjourn

Director Butler, seconded by Director Muñoz, moved to adjourn. THE MOTION CARRIED UNANIMOUSLY AND THE MEETING ADJOURNED.

Respectfully submitted,
Board of Directors of the
Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXXX
Warren L. Batts, Chairman

Attest:

XXXXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary

ATTACHMENT #1

Integrated Clinical Solutions, Inc.

Cook County Health and Hospitals System

Strategic Planning: Board Progress Report + Discussion

September 18, 2009

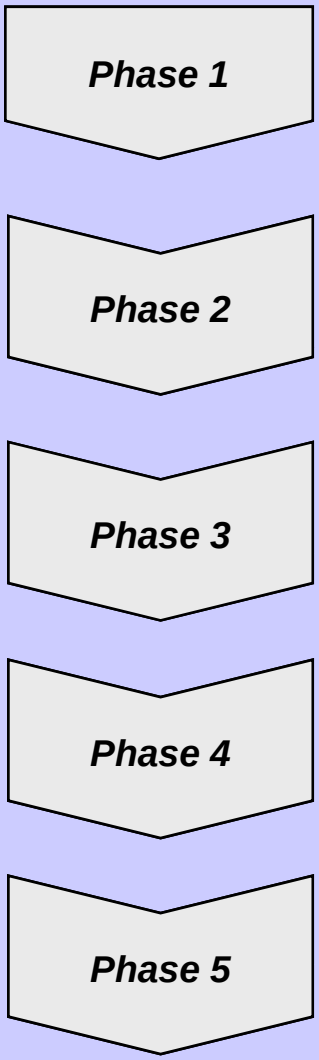
Agenda

- **Process Overview and Progress Update**
- **Current State:**
  - **Market Characteristics**
  - **CCHHS Overview**
- **Financial Planning Update**
- **Interview/Focus Group Feedback**
- **Town Hall Meeting Input (Preliminary)**
- **Discussion: Core Themes + Design Principles**
- **Next Steps**

Agenda

- **Process Overview and Progress Update**
- Current State:
  - Market Characteristics
  - CCHHS Overview
- Financial Planning Update
- Interview/Focus Group Feedback
- Town Hall Meeting Input (Preliminary)
- Discussion: Core Themes + Design Principles
- Next Steps

Process Overview



Phase 1 – Kick-off & Retreat:

- ***Set the Stage for the Planning Process***

Phase 2 – Discovery:

- ***Evaluate Current Position and Opportunities***

Phase 3 – Strategic Direction:

- ***Develop a Shared Vision and Strategic Direction***

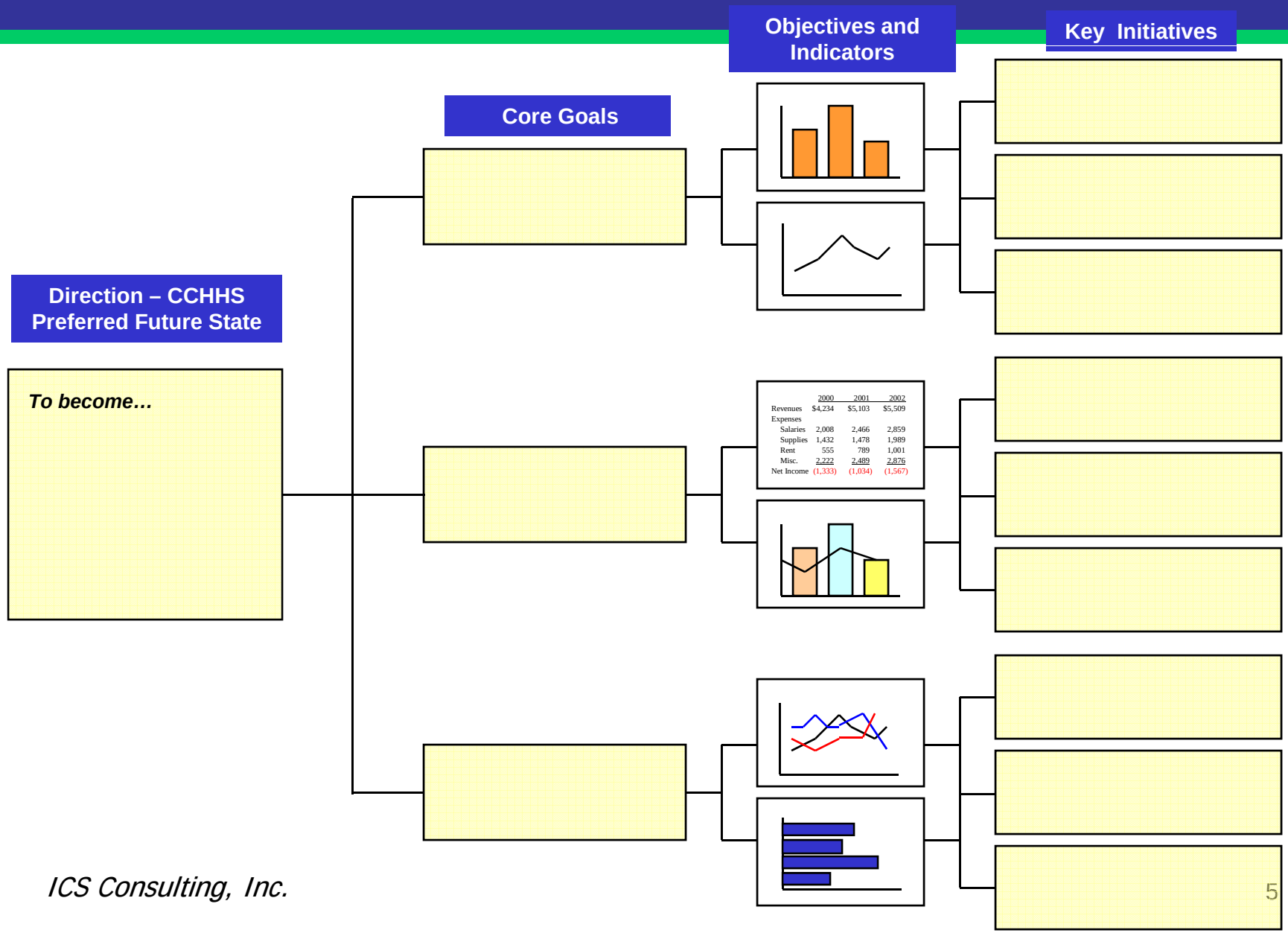
Phase 4 – Financial Plan:

- ***Develop a 3-year Financial Plan***

Phase 5 – Action Plan:

- ***Specify Action Plan and Accountabilities***

Process Outcomes—CCHHS Direction, Focus, and Action



ICS Consulting, Inc.

Major Steps

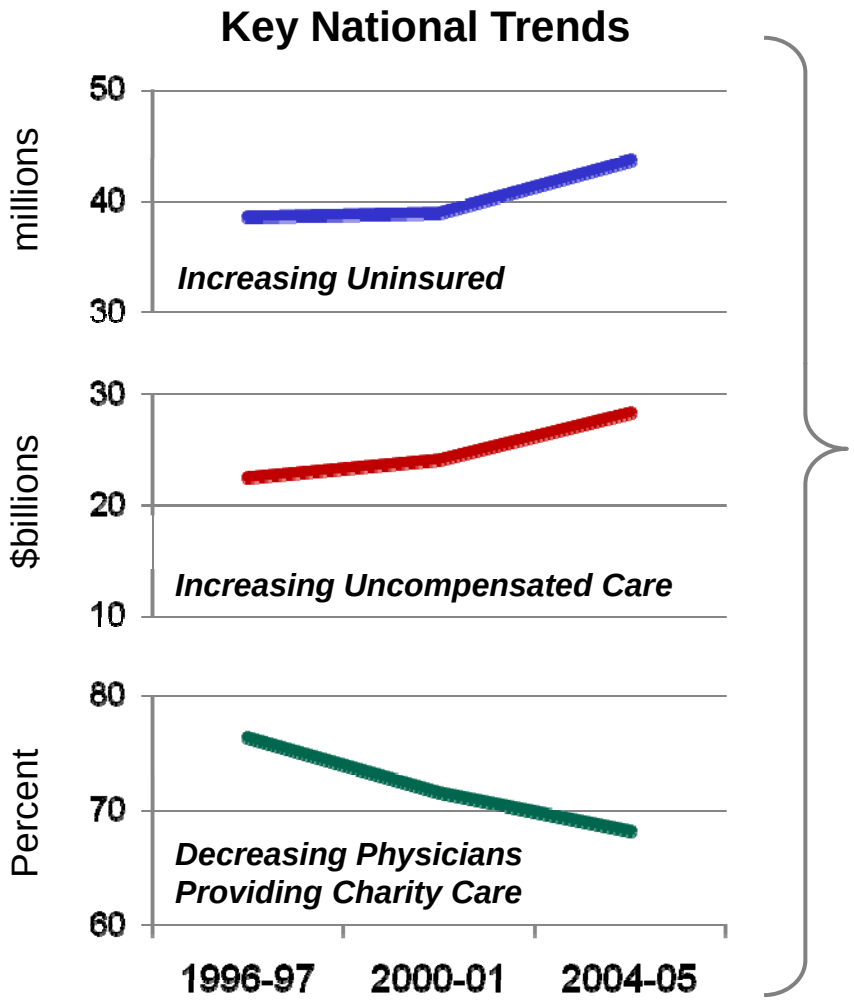
Phase 2 —Discovery:
Evaluate Current Position & Opportunities

- External Market Analysis
- CCHHS Profile & Analysis
- Site Visits
- Financial Data Bases
- Interviews & Focus Groups
- Patient Interviews
- Town Hall Meetings

Agenda

- Process Overview and Progress Update
- **Current State:**
  - **Market Characteristics**
  - **CCHHS Overview**
- Financial Planning Update
- Interview/Focus Group Feedback
- Town Hall Meeting Input (Preliminary)
- Discussion: Core Themes + Design Principles
- Next Steps

Nationally, health system pressures are making it increasingly difficult for safety-net providers to maintain their mission



Impact on Public Hospitals

- Increased demand for services
- Decreased access to specialty care, notably mental health, surgical care, dental, and vision care most difficult to obtain
- Increase in the amount of uncompensated care provided
- Competition with non-safety-net providers

Source: Health Affairs, August 12 ,2008

Cook County is estimated to have the third largest uninsured population in the U.S., although the percentage of uninsured is lower than many other counties

Uninsured by County, Top 10, 2005

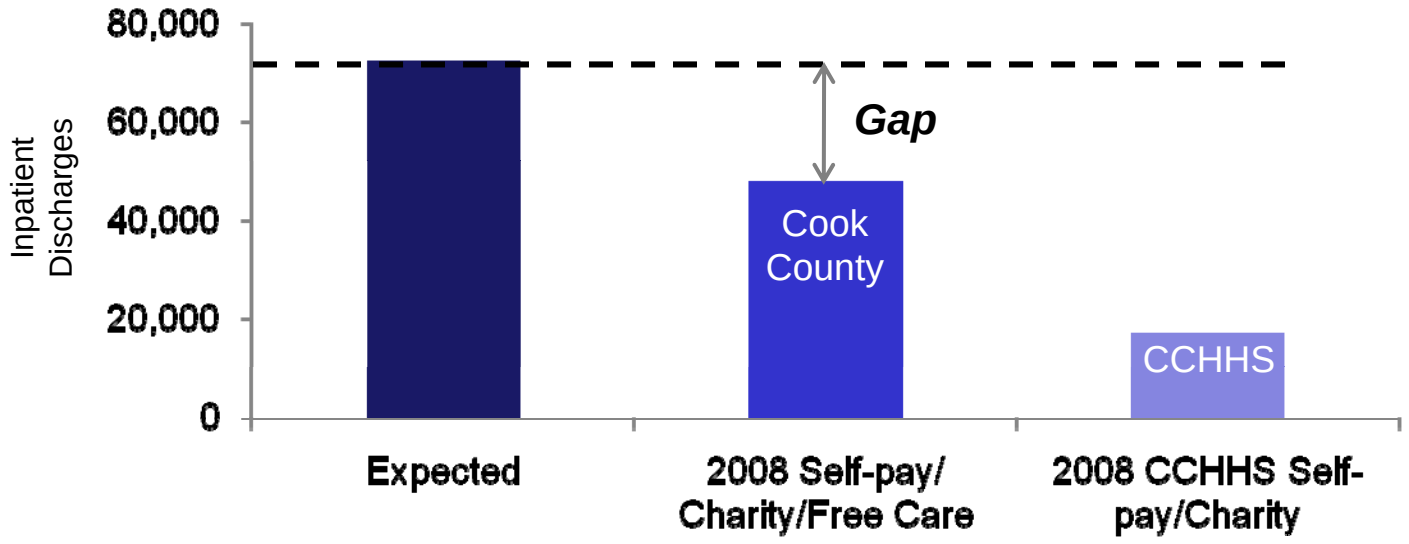
	Age 0-64			Age 19-64		
County	Number Uninsured	Percent Uninsured	Margin of Error	Number Uninsured	Percent Uninsured	Margin of Error
Los Angeles County, California	2,047,332	23.4%	0.9	1,744,275	28.3%	1.1
Harris County, Texas	1,140,803	32.0	1.5	885,108	36.2	1.8
Cook County, Illinois	**784,930**	**16.9**	**1.0**	**653,691**	**19.8**	**1.2**
Maricopa County, Arizona	702,940	21.3	1.1	546,301	24.0	1.4
Dallas County, Texas	616,973	29.1	1.7	461,060	31.8	2.0
Miami-Dade County, Florida	599,047	29.6	1.6	493,390	33.7	1.9
Orange County, California	566,296	21.5	1.4	454,764	24.6	1.6
San Diego County, California	541,560	21.6	1.5	415,409	23.5	1.7
Riverside County, California	472,455	26.8	1.8	364,528	30.1	2.2
San Bernardino County, California	414,035	23.2	1.0	322,638	26.8	2.2

Source: U.S. Census Bureau, Small Area Health Insurance Estimates/County and State by Demographic and Income Characteristics/2005

Inpatient demand clearly exceeds existing service levels

Expected IP Discharges for Uninsured

Cook County Use Rate*		Est. Uninsured Pop.		Expected Dischgs.
92.1 discharges/ 1000 population	X	785,000	=	72,281



* Reflects discharges per 1000 population for ages 0-64
Sources: CompData, U.S. Census Bureau

The vulnerable population is highest in the city of Chicago

Health Insurance Coverage, Age 19-64, 2005

	Private Insurance		Medicaid		Medicare		Uninsured	
	Women	Men	Women	Men	Women	Men	Women	Men
Illinois	75.2%	74.7%	7.5%	4.3%	3.1%	3.1%	16.9%	20.3%
Chicago	63.3%	62.6%	11.5%	5.9%	4.4%	4.1%	24.3%	29.6%
Suburban Chicago	82.9%	81.0%	3.1%	2.1%	2.4%	2.0%	13.9%	16.6%
Downstate	72.7%	74.1%	10.7%	6.2%	3.2%	4.0%	15.9%	19.3%

Source: Rob Paral and Associates' analysis of the Current Population Survey for Health & Disability Advocates, covering calendar years 2001-2005 for insurance rates. The 2005 American Community Survey was used for population estimates.

Segmenting the uninsured: a much higher percent of men, Latinos, and those aged 19-25

Uninsured In Illinois by Demographic Characteristics, 2005, Age 19-64

Demographic Category	% Uninsured Women Within Each Category	% Uninsured Men Within Each Category
Total	16.9%	20.3%
By Geographic Area		
Chicago	24.3%	29.6%
Suburban Chicago	13.9%	16.6%
Downstate	15.9%	19.3%
By Age		
Age 19 to 24 years	26.5%	34.9%
Age 25 to 49 years	16.6%	20.9%
Age 50 to 64 years	13.3%	11.8%
By Race		
White	12.0%	13.6%
Latina/o	33.1%	40.0%
African American	25.9%	31.4%
By Employment Status		
Employed full time year round	10.8%	13.2%
Employed less than full time year round	18.0%	30.0%
Not employed	23.2%	31.5%
By Income Level		
Income < 100% of poverty	39.4%	54.8%
Income < 200% of poverty	34.8%	46.3%
Income < 300% of poverty	28.6%	37.5%
Income < 400% of poverty	24.3%	31.7%
Income > 400% of poverty	7.5%	8.3%

Source: A Study of Uninsured Women in Illinois, Rob Paral & Associates, 2007

Notes: In 2005, 100% of poverty was approximately $10,000 for an individual and $20,000 for a family of four.
*Insured/uninsured do not sum to totals due to more detailed adjustments by age, race, employment status and income level.

The disease burden is greater in minority populations, particularly in the African-American community

10 Leading Causes of Death by Race/Ethnicity for 2005 in Chicago

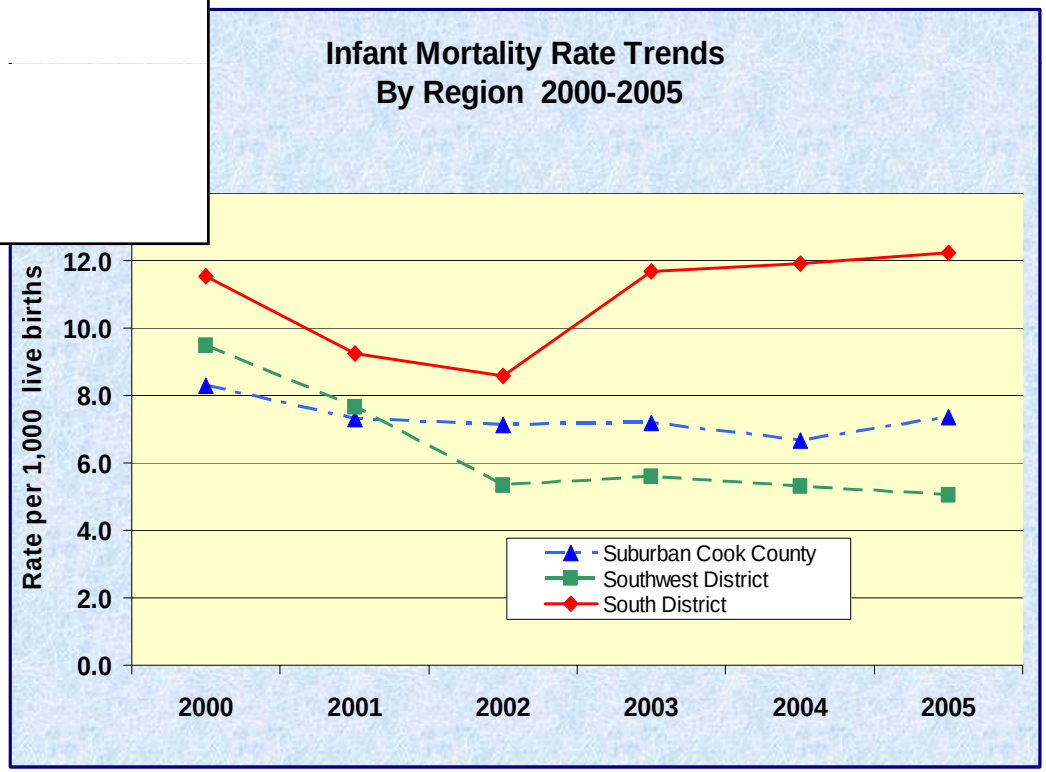
Causes of Death	All Races	Hispanic	Mexican	Puerto Rican	Asian	Black	White
Heart Disease	265.4	132	152.7	202.5	141.5	365.7	275.2
Cancer	204.6	109.5	121.6	175.1	132.7	304.4	193.6
Stroke	49.5	22.7	32.8	RS	27.2	75.5	45.3
Chronic Lwr Resp Dis	33.2	RS	RS	RS	RS	40.9	38.9
Diabetes	29	31.6	36.3	60.6	25.6	41.9	22.9
Nephritis	22.5	RS	18.1	RS	RS	39.2	16.4
Alzheimer's Disease	RS	RS	RS	RS	RS	RS	17.6
Homicide	16.4	9.6	9.6	RS	RS	36.2	RS
Septicemia	25.5	20	21.4	50.1	RS	44.2	19.3
Influenza & Pneumonia	23	14.4	RS	RS	RS	29	24.6
Accidents	33.9	26.1	25.9	40.8	RS	49.6	30.6
Liver Disease	RS	16.9	15.6	36.5	RS	RS	RS
Infant Mortality	RS	4.3	3.7	RS	RS	RS	RS

RS = Rate Suppressed because the number of deaths < 21

SOURCE: CDPH

Health indicators in the South region of the County demonstrate the disparities

Maternal and Child Health Indicator

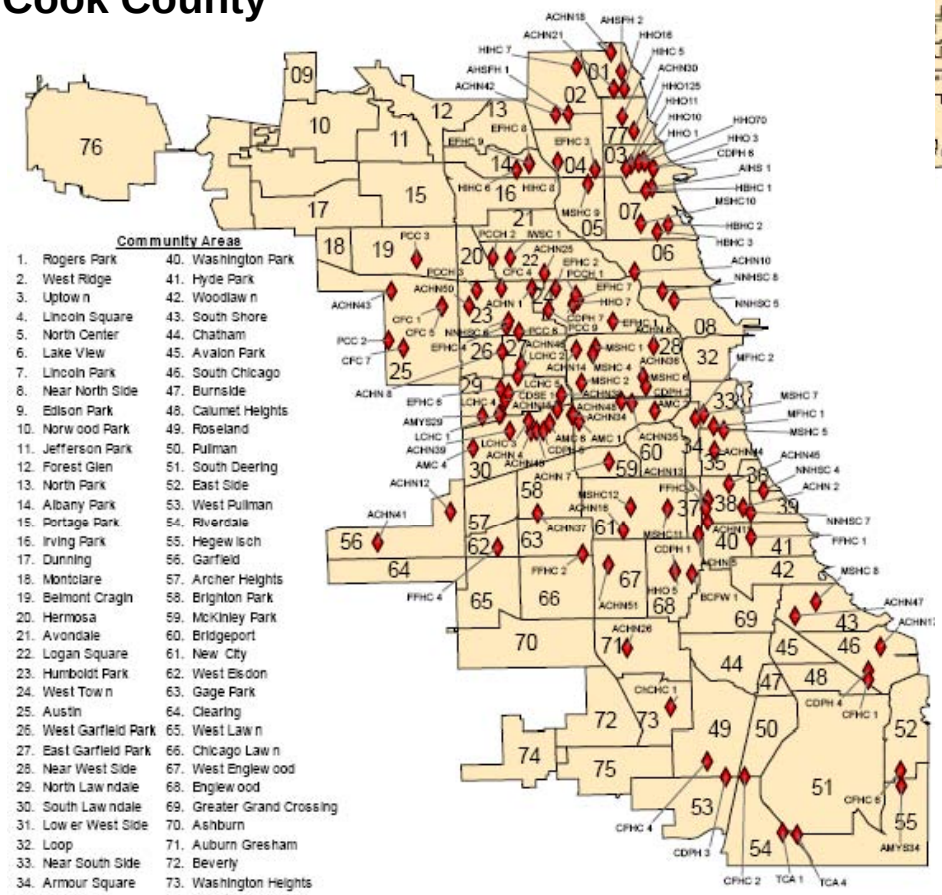


SOURCE: CDPH

ICS Consulting, Inc.

There are a very large number of community health centers; however the southern parts of Chicago and the County still appear to be underserved

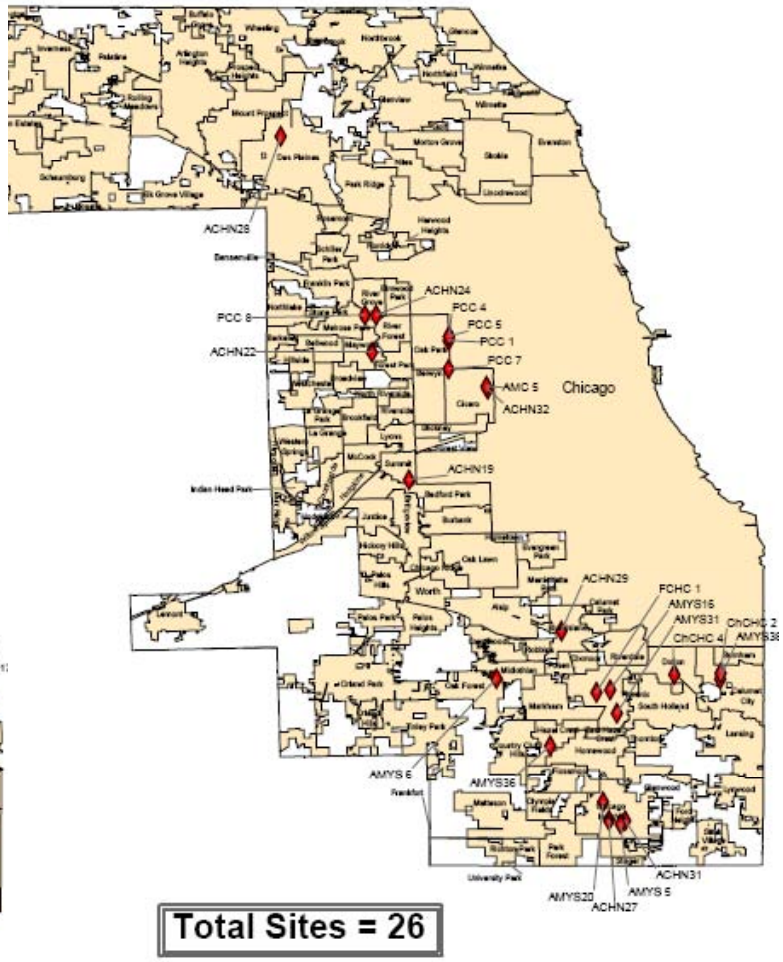
Community Health Center Locations, Cook County



Community Areas

1.	Rogers Park	40.	Washington Park
2.	West Ridge	41.	Hyde Park
3.	Uptown	42.	Woodlawn
4.	Lincoln Square	43.	South Shore
5.	North Center	44.	Chatham
6.	Lake View	45.	Avalon Park
7.	Lincoln Park	46.	South Chicago
8.	Near North Side	47.	Burnside
9.	Edison Park	48.	Calumet Heights
10.	Norwood Park	49.	Roseland
11.	Jefferson Park	50.	Pullman
12.	Forest Glen	51.	South Deering
13.	North Park	52.	East Side
14.	Albany Park	53.	West Pullman
15.	Portage Park	54.	Riverdale
16.	Irving Park	55.	Hegewisch
17.	Dunning	56.	Garfield
18.	Montclare	57.	Archer Heights
19.	Belmont Cragin	58.	Brighton Park
20.	Hermosa	59.	McKinley Park
21.	Avondale	60.	Bridgeport
22.	Logan Square	61.	New City
23.	Humboldt Park	62.	West Elsdon
24.	West Town	63.	Gage Park
25.	Austin	64.	Clearing
26.	West Garfield Park	65.	West Lawn
27.	East Garfield Park	66.	Chicago Lawn
28.	Near West Side	67.	West Englewood
29.	North Lawndale	68.	Englewood
30.	South Lawndale	69.	Greater Grand Crossing
31.	Lower West Side	70.	Ashburn
32.	Loop	71.	Auburn Gresham
33.	Near South Side	72.	Beverly
34.	Armour Square	73.	Washington Heights
35.	Douglas	74.	Mount Greenwood
36.	Oakwood	75.	Morgan Park
37.	Fuller Park	76.	O'Hare
38.	Grand Boulevard	77.	Edgewater
39.	Kenwood		

Total Sites = 125



Total Sites = 26

Source: Illinois Primary Healthcare Association, 2/2009

In fact, the areas of greatest health need have fewer accessible community health options

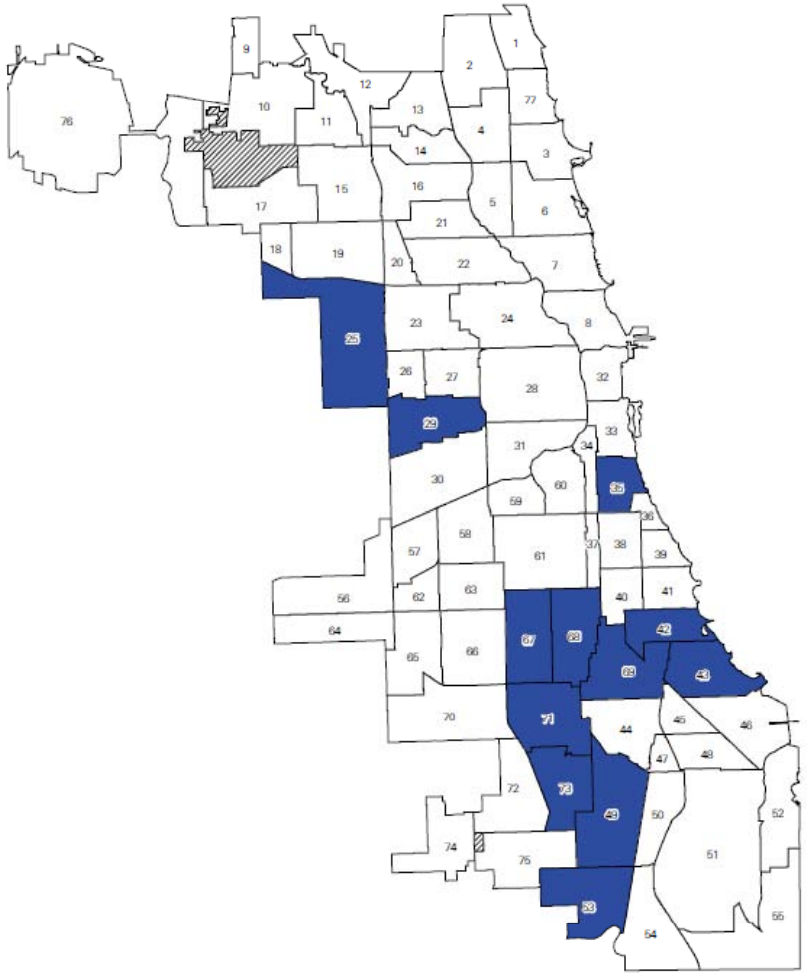
Community Areas with Lowest Health Ranking

WEST
Austin (#25)
North Lawndale (#29)

SOUTH
Douglas (#35)
Englewood (#67)
West Englewood (#68)
Greater Grand Crossing (#69)
Woodlawn (#42)
South Shore (#43)
Auburn Gresham (#71)
Washington Heights (#73)
Roseland (#49)
West Pullman (#53)

Source: CDPH

Figure 47 Chicago Community Areas with the Lowest Health Ranking Composite, 2004



Current State Profile

- Who We Serve
- What We Do
- How We Do

CCHHS offers a large network of hospitals and health centers to the residents of Cook County

Cook County Health and Hospitals System

Hospitals

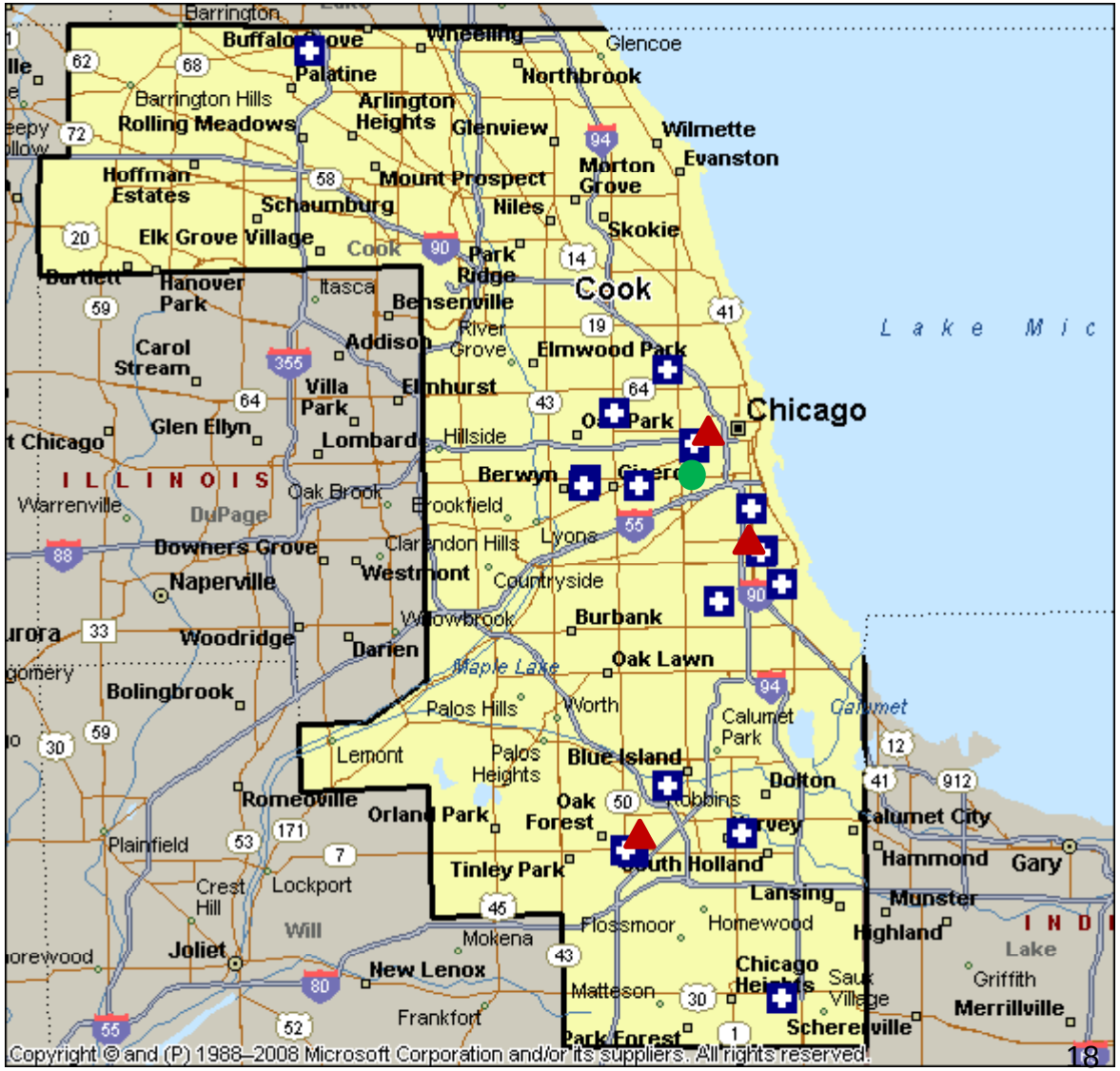
1. J.H. Stroger, Jr. Hospital/Core Center
2. Provident Hospital
3. Oak Forest Hospital

Ambulatory and Community Health Network

1. Austin Health Center
2. Cicero Health Center
3. Englewood Health Center
4. Cottage Grove Health Center
5. Dr. Jorge Prieto Health Center
6. Fantus Health Center
7. Sengstacke [Provident] Health Center
8. John Stroger Specialty Care Center
9. Logan Square Health Center
10. Morton East School Health Ctr.
11. Near South Health Clinic
12. Oak Forest Specialty Health Center
13. Robbins Health Center
14. Vista Health Center
15. Woodlawn Health Center
16. Woody Winston Health Center

Cermak Health Services

ICS Consulting, Inc.



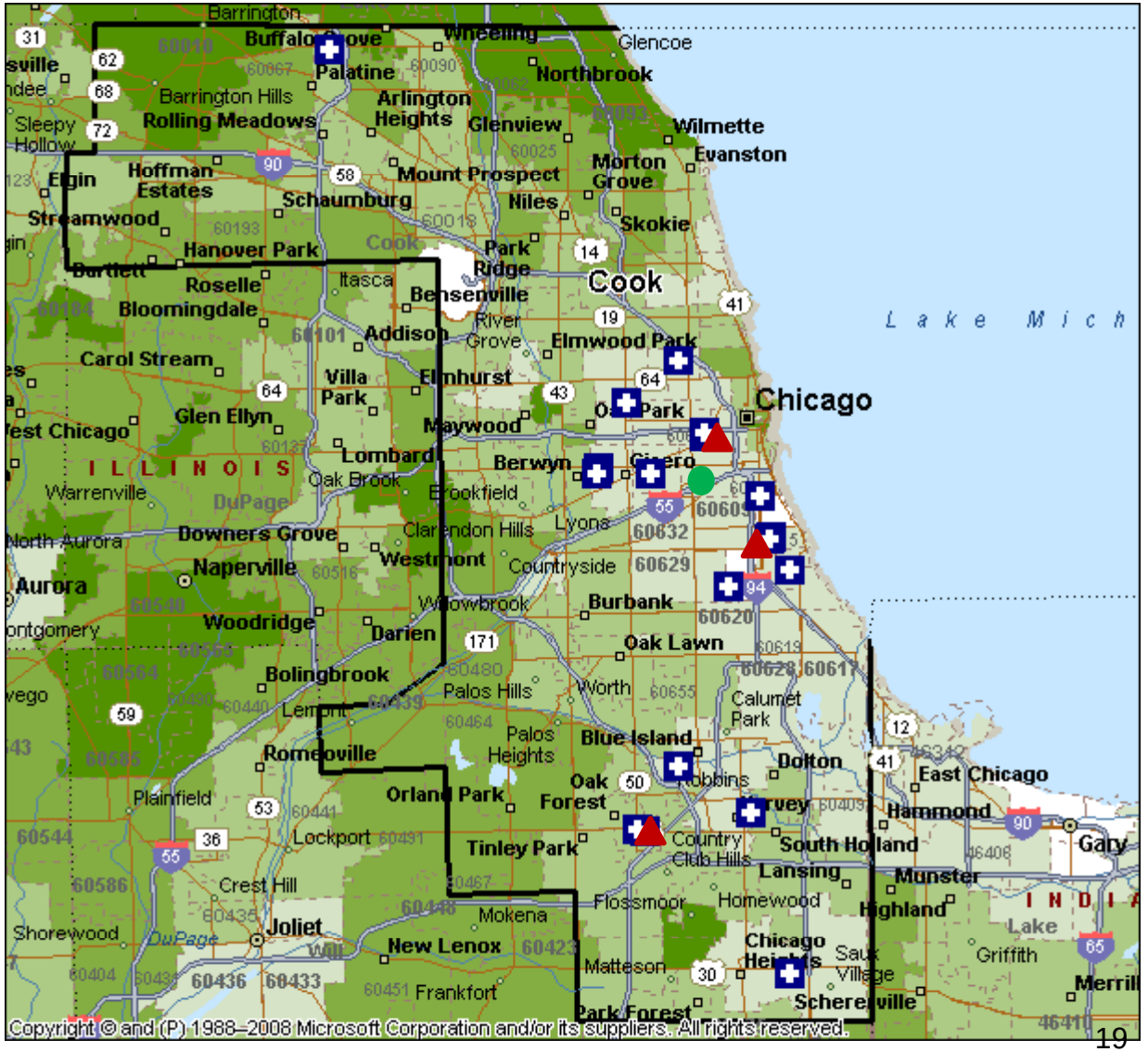
CCHHS facilities are well-placed to serve the poorer areas of the county but there are most certainly some gaps

CCHHS Locations and Median Household Income by ZIP Code

- **Hospitals**
- **Ambulatory and Community Health Network**
- **Cermak Health Services**

Median HH Income (2007)

- $100,000 to $500,000
- $75,000 to $99,999
- $50,000 to $74,999
- $25,000 to $49,999
- $0 to $24,999



Source: CCHHS

ICS Consulting, Inc.

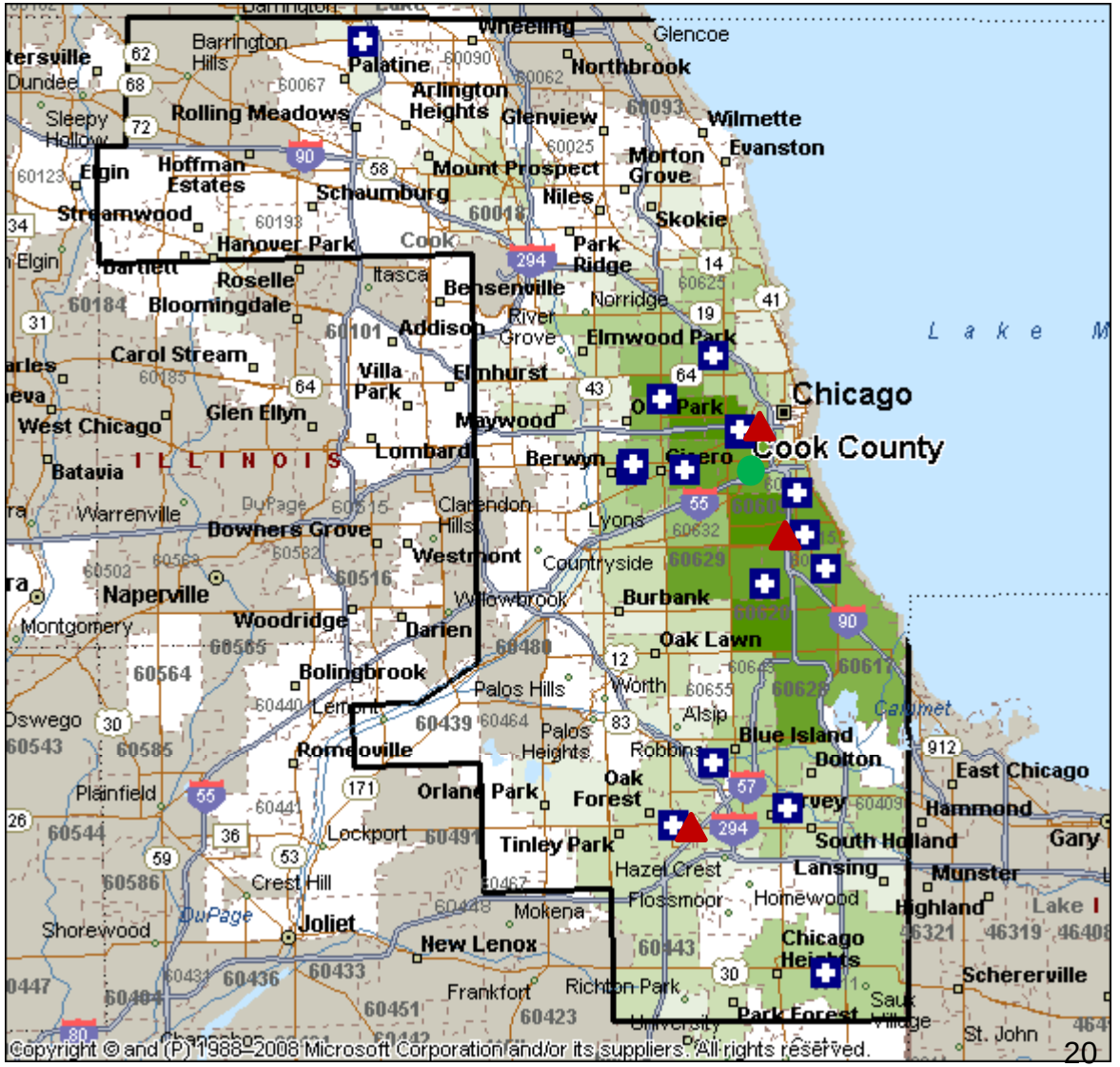
As expected, CCHHS draws inpatients primarily from the poorer areas of the county

Inpatient Origin by ZIP Code, 2008

- **Hospitals**
- **Ambulatory and Community Health Network**
- **Cermak Health Services**

CCHHS Inpatients*, 2008

- 1,250 to 1,499
- 1,000 to 1,249
- 750 to 999
- 500 to 749
- 250 to 499
- 100 to 249
- 50 to 99
- 10 to 49



20

* Excludes ZIP codes with less than 10 inpatients

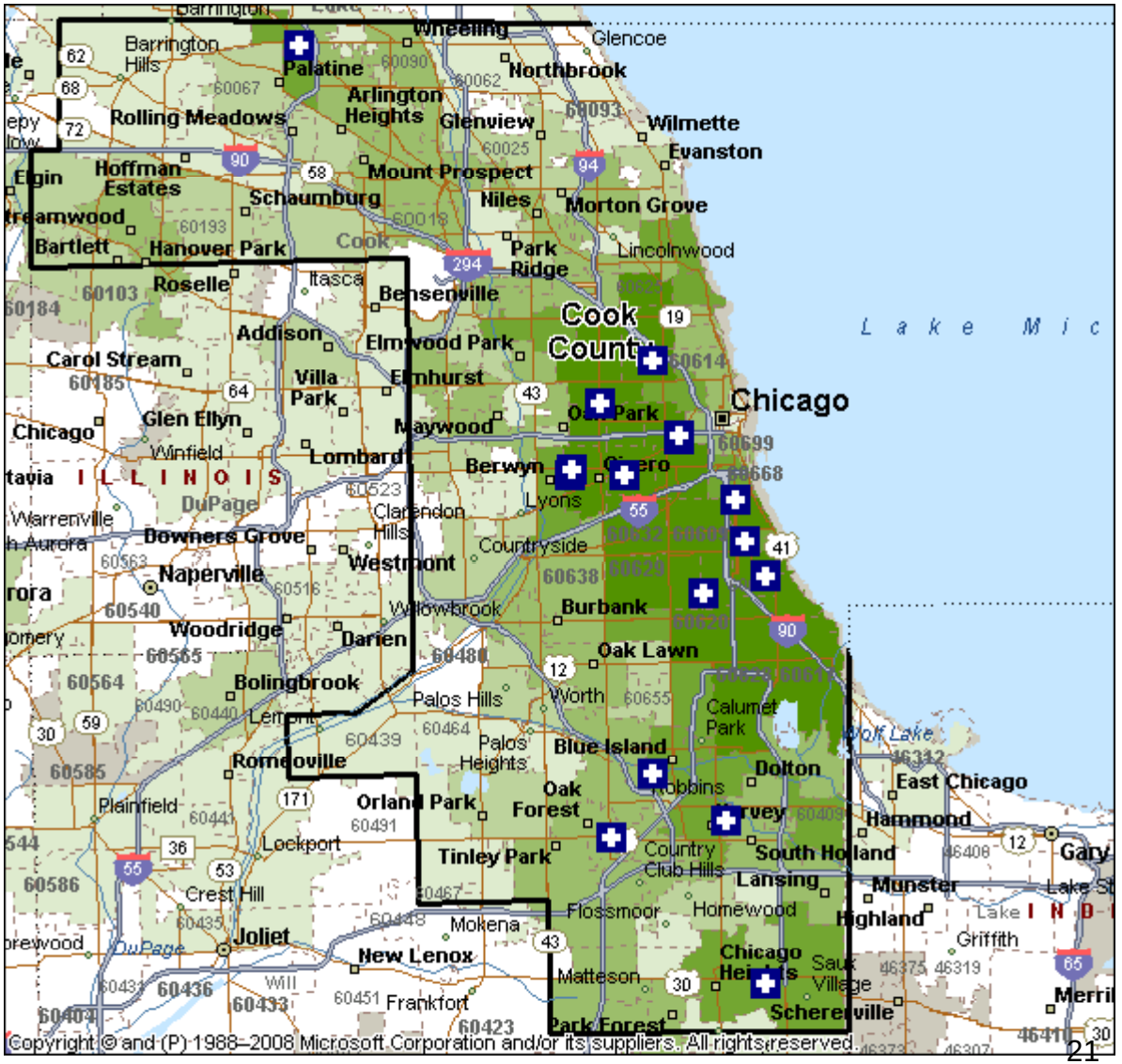
Source: CCHHS

ICS Consulting, Inc.

Outpatients, however, come from a much broader service area

Outpatient Origin by ZIP Code, 2008

Ambulatory and Community Health Network



CCHHS Outpatients*, 2008

- 10,000 to 30,000
- 5,000 to 9,999
- 1,000 to 4,999
- 500 to 999
- 100 to 499
- 10 to 99

* Data includes outpatient visits from the distributed, Stroger, Provident, and OF clinics and health centers. Excludes ZIP codes with less than 10 outpatient visits.

Source: CCHHS

ICS Consulting, Inc.

CCHHS has a huge OP business on a comparatively modest inpatient platform, particularly at Provident and Oak Forest Hospitals

CCHHS Utilization Statistics and Cost, 2008

Patient Activity	Stroger	Provident	Oak Forest	Distrib. Clinics	CORE *	Cermak	CCDPH/ TB	Central Admin	TOTAL
ACHN Visits	394,629	26,726	18,951	132,002	31,280	**	***		603,588
Admissions	23,248	5,191	2,799						31,238
Patient Days	116,097	20,815	23,787						160,699
ALOS	5.0	4.0	8.5						5.1
ER Visits	128,599	40,370	28,768						197,737
Case Mix Index	1.114	0.964	0.985						
Budget Est. ('000s)	$660,559	$ 127,515	$126,854	$ 14,031	$ 26,619	$56,293	$23,929	$42,024	1,077,824
Percent	61.3%	11.8%	11.8%	1.3%	2.5%	5.2%	2.2%	3.9%	100%

Source: Mike Koetting analysis using FY08 Financial Work Papers

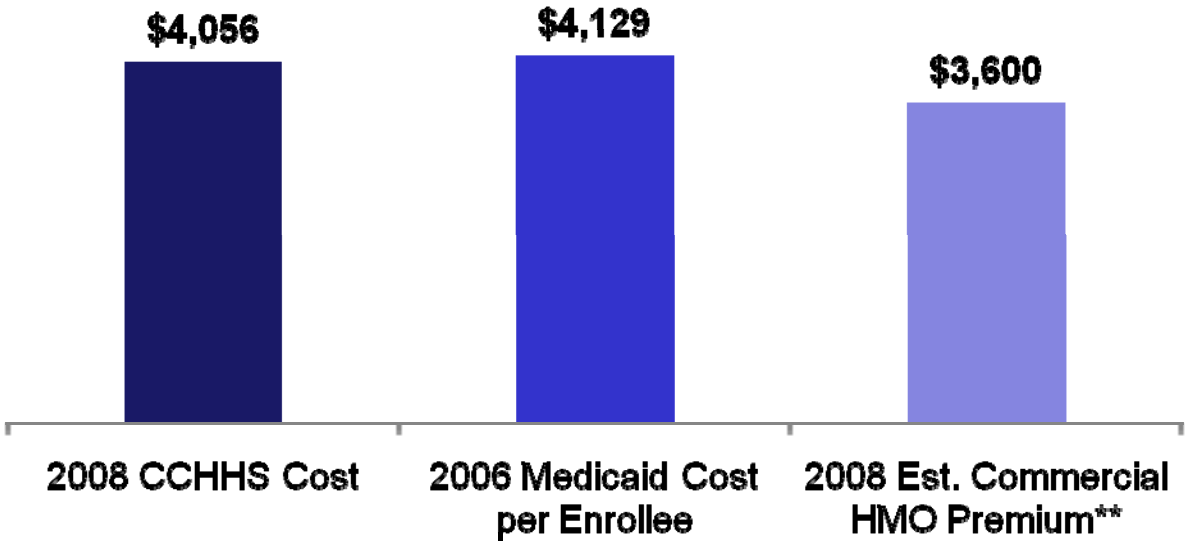
Notes:
* Includes only County-funded visits; provides another 30,000 visits with other funding
** Provides health services for Cook County Jail detainees, about 10,000 at one time, 100,000 over the course of a year
*** Maintains several clinics--including very heavily used dental clinics and STD clinics

CCHHS spent approximately $4,000 per unique patient served

Estimated CCHHS Cost per Unique Patient, 2008

$997,602,000 Est. CCHHS Cost* ÷ **245,976 unique patients served** → **Cost = $4,056 per unique patient**

By Comparison:

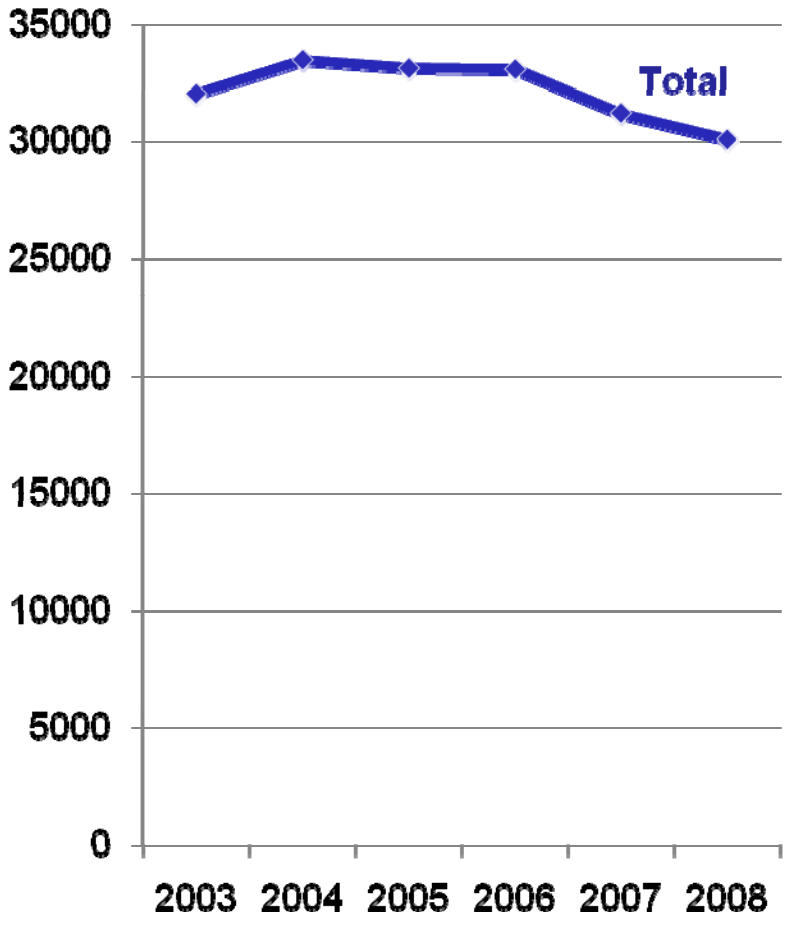


* Excludes costs for Cermak and CCDPH/TB locations
** Commercial HMO Premium estimated at $300 PMPM using historic Illinois data and 2008 National data

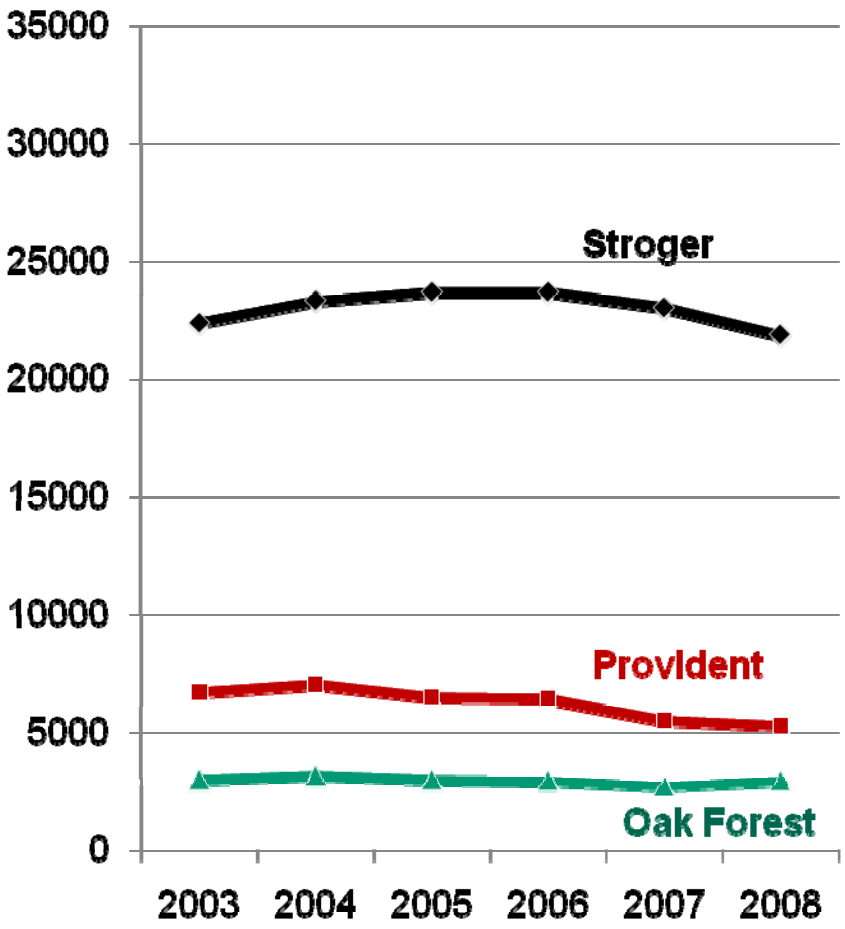
Source: Mike Koetting analysis using FY08 Financial Work Papers

While healthcare needs in the County have grown, CCHHS inpatient activity has declined over the last five years, primarily due to budget cuts

Trended IP Discharges



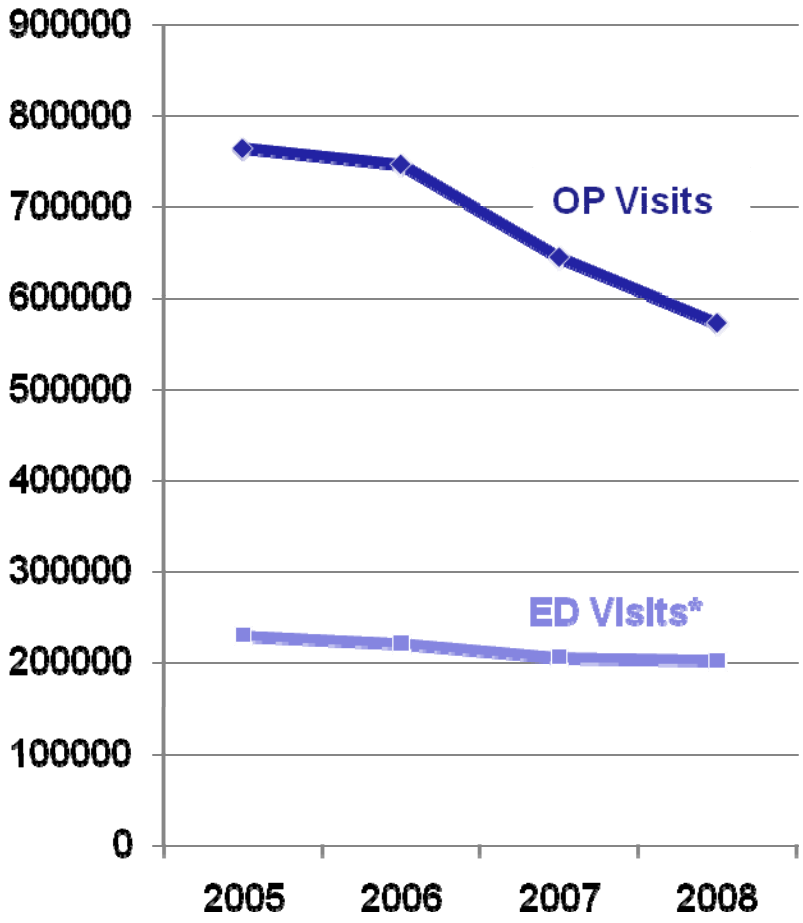
Trended IP Discharges by Site



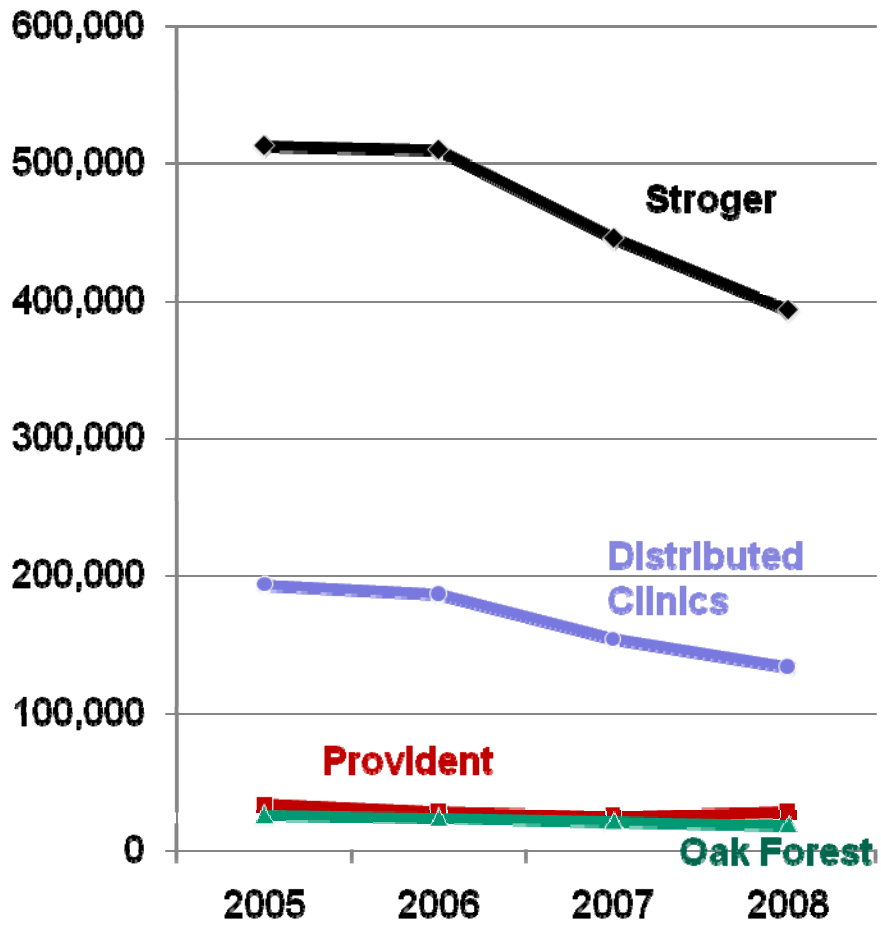
Source: CCHHS

CCHHS outpatient activity has also declined over the last several years, due to budget cuts

Trended OP and ER Visits



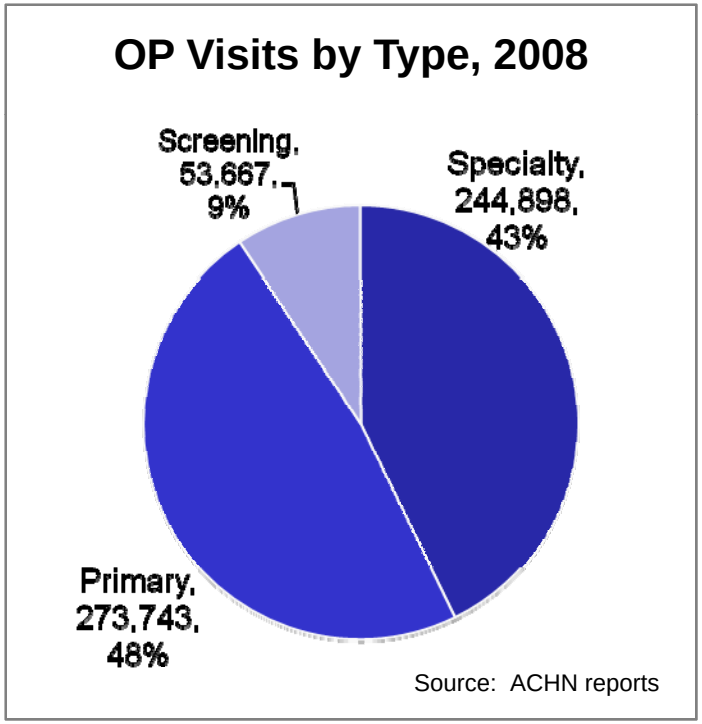
Trended OP Visits by Site

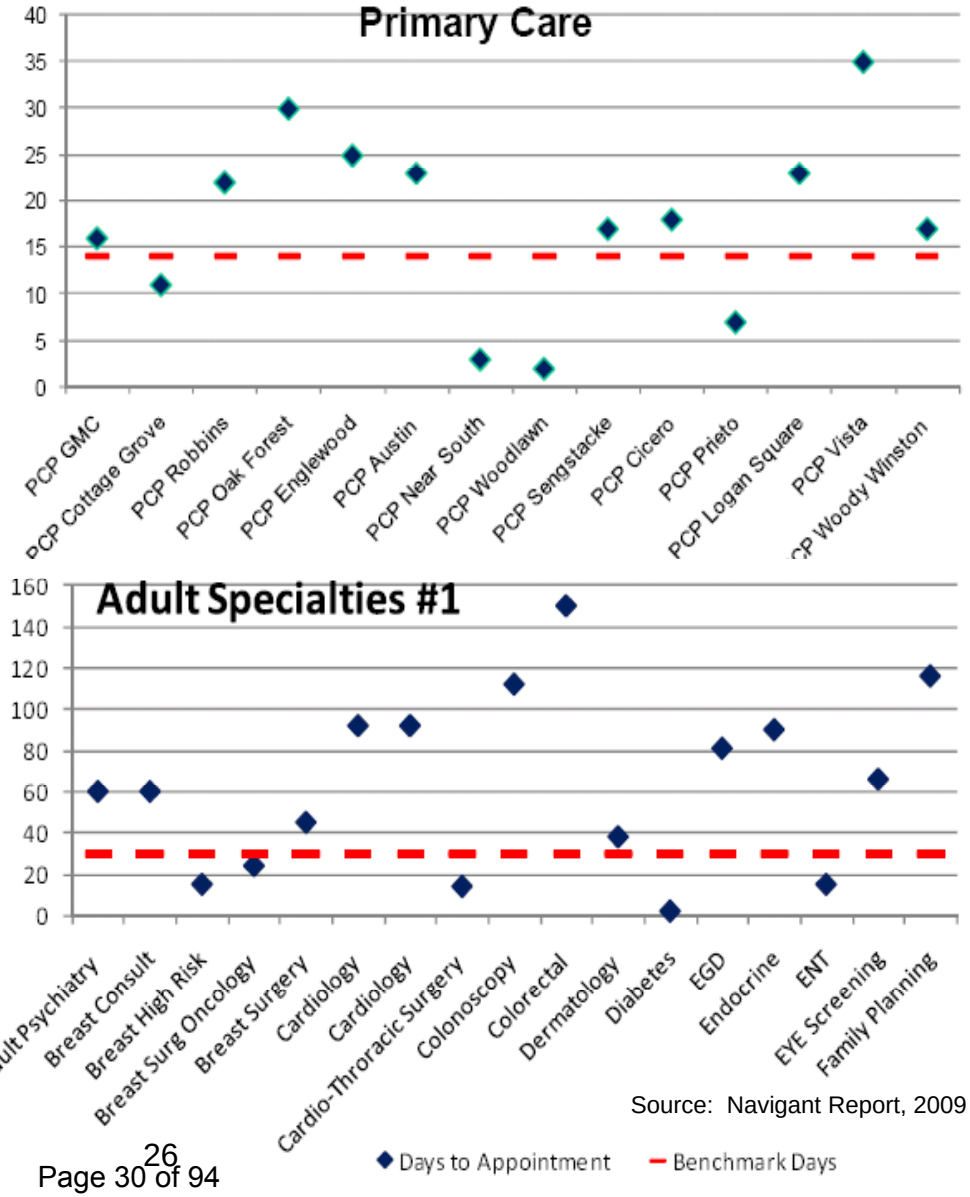


* Excludes Trauma
Source: CCHHS

CCHHS has long waits for both primary care and specialty care clinics

Appointment Availability to Primary Care and Specialty Clinics



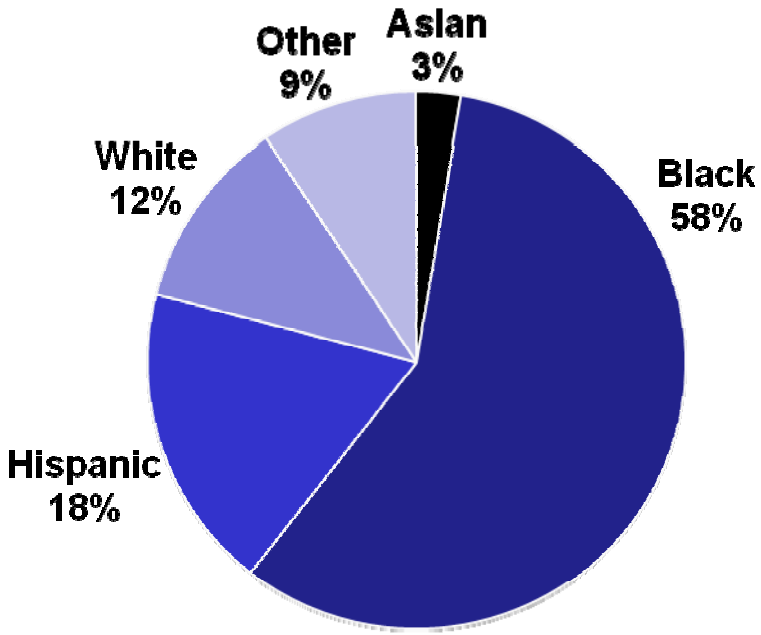


Source: Navigant Report, 2009

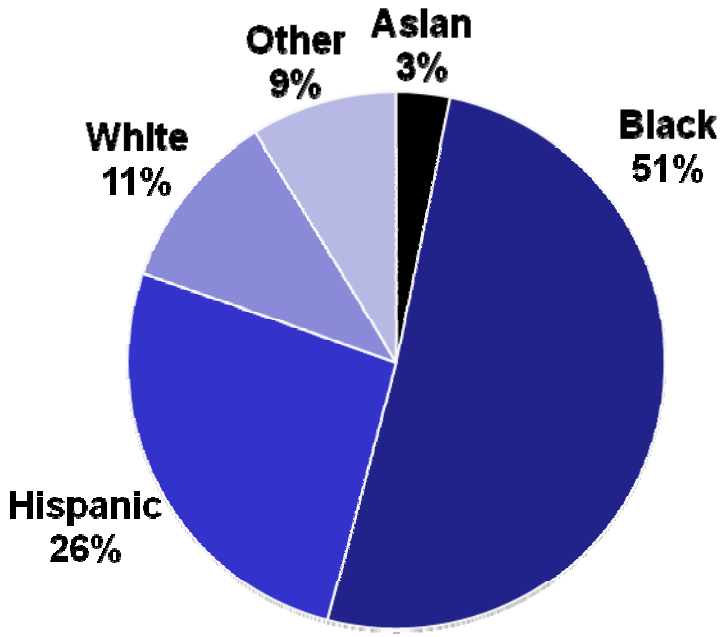
ICS Consulting, Inc.

CCHHS serves primarily an African-American population, more so on the inpatient side

Inpatients by Race, 2008



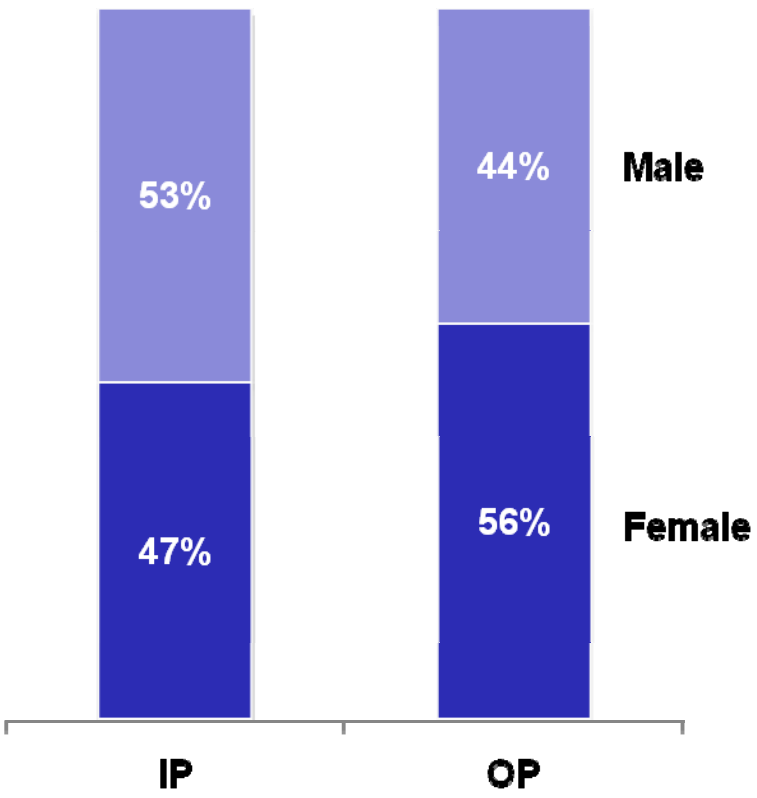
Outpatients* by Race, 2008



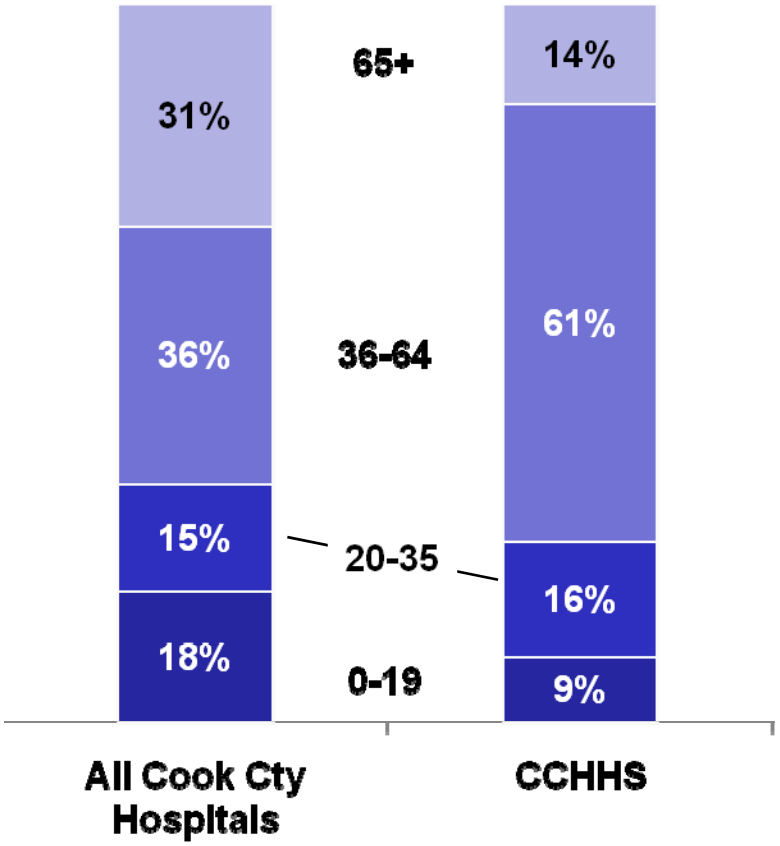
* Excludes ER
Source: CCHHS

CCHHS has a unique distribution of patients by sex and age, reflecting the insurance status of patients

CCHHS Patients by Sex, 2008



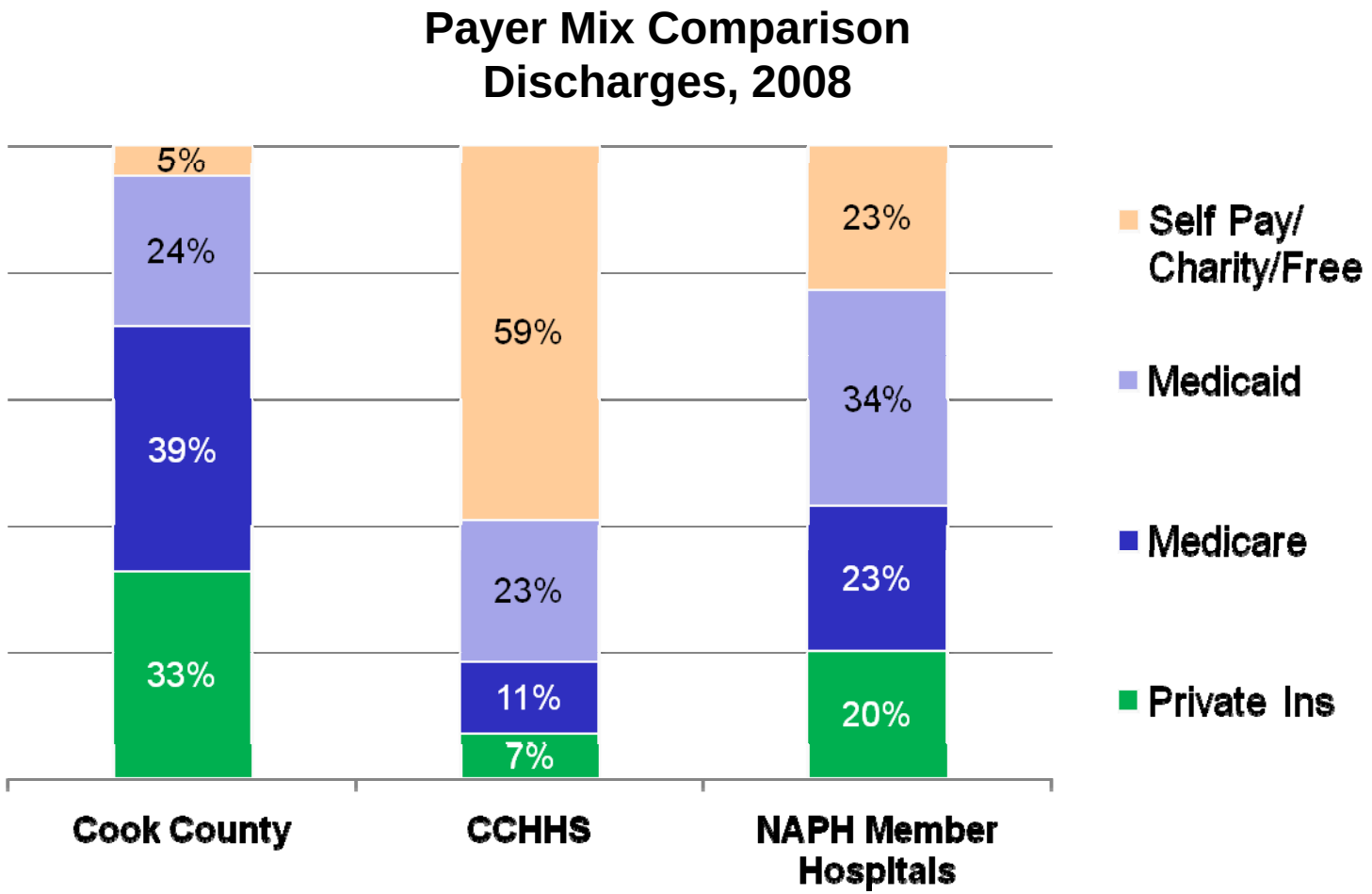
Inpatients by Age, 2008



* Excludes ER
Source: CCHHS: CompData

ICS Consulting, Inc.

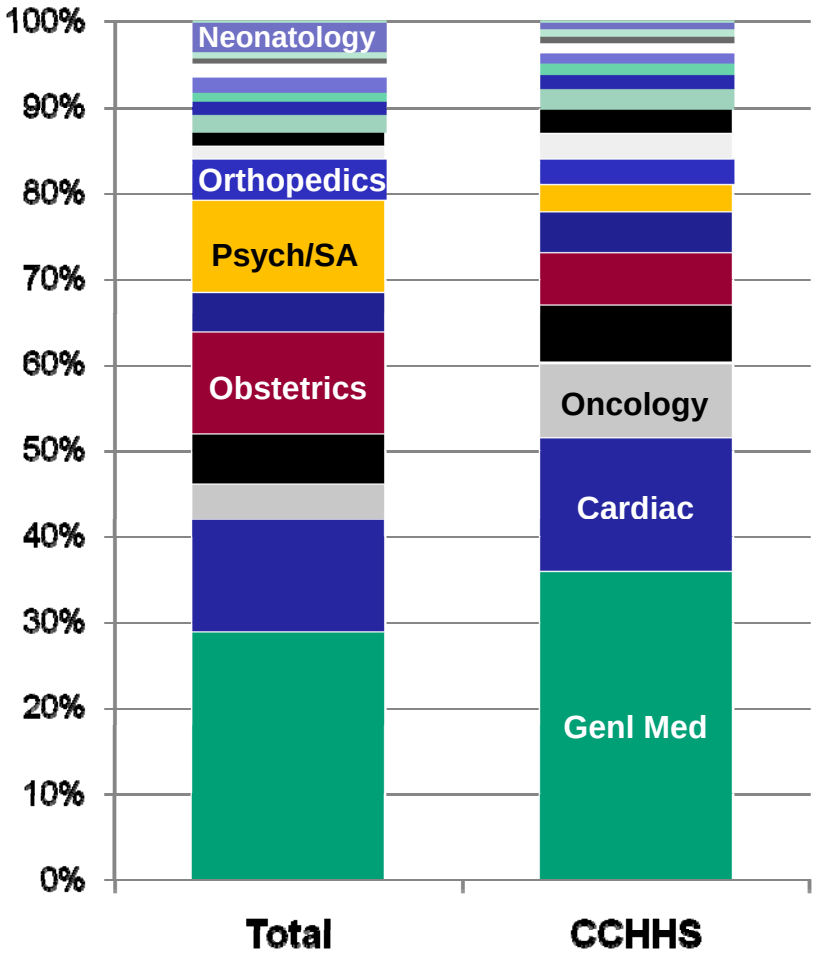
CCHHS provides a disproportionate share of the self-pay/ charity care in the County



Note: Excludes normal newborns
Source: CompData; National Association of Public Hospitals

CCHHS has a considerably different service mix relative to Cook County discharges overall

IP Service Mix Comparison, 2008



Service Line	Cook Cty	CCHHS
General Medicine	28.7%	35.8%
Cardiac Services	13.2%	15.5%
Oncology	3.9%	8.8%
General Surgery	5.9%	6.7%
Obstetrics	11.9%	6.1%
Neurology	4.6%	4.7%
Psych/Subst. Abuse	10.8%	3.2%
Orthopedics	4.7%	3.0%
ENT	1.5%	2.9%
Gynecology	1.6%	2.8%
Vascular Services	2.1%	2.3%
Urology	1.5%	1.7%
Trauma	1.0%	1.3%
Rehabilitation	1.8%	1.2%
Spine	1.7%	1.2%
Neurosurgery	0.6%	0.8%
Thoracic Surgery	0.7%	0.8%
Neonatology	3.4%	0.8%
Other	0.3%	0.3%
Total	**100.0%**	**100.0%**

Note: IP numbers exclude normal newborns; CCHHS data appears to be underreported by about 8%
Source: CompData

Both Provident and Oak Forest have a service mix that is driven by ER activity. OF has a longer ALOS driven by the Rehab service and also General Medicine

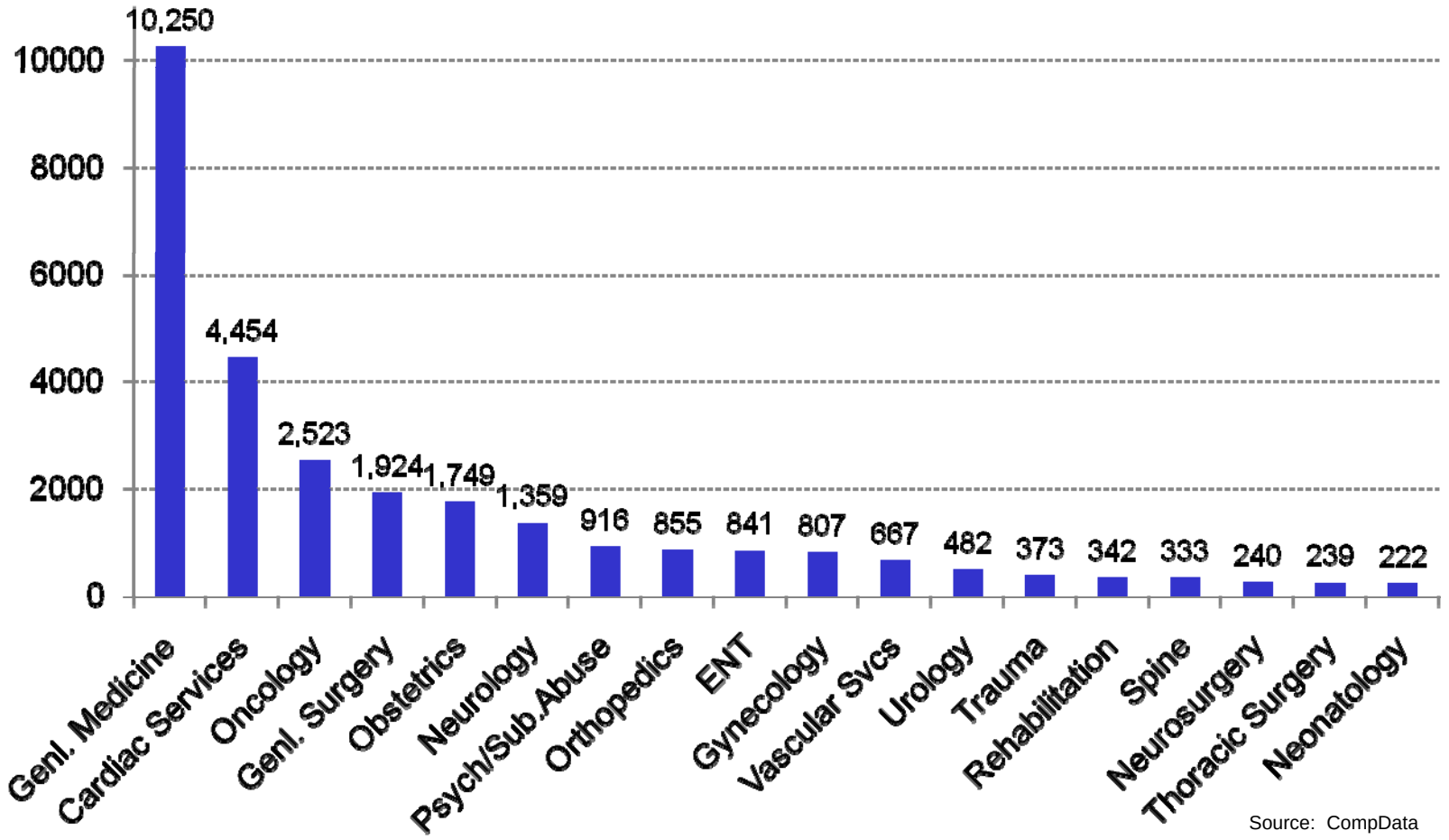
IP Service Mix Comparison by Hospital, 2008

	Stroger			Provident			Oak Forest			Total CCHHS			Cook County
Service Line	Dischgs	Percent	Days	Dischgs	Percent	Days	Dischgs	Percent	Days	Dischgs	Percent	Days	Percent
General Medicine	6,990	34%	25,857	2,017	40%	9,060	1,243	43%	8,549	10,250	36%	43,466	29%
Cardiac Services	2,488	12%	9,060	1,403	28%	4,798	563	20%	2,179	4,454	16%	16,037	13%
Oncology	2,273	11%	10,005	148	3%	655	102	4%	359	2,523	9%	11,019	4%
General Surgery	1,634	8%	15,463	147	3%	1,400	143	5%	1,349	1,924	7%	18,212	6%
Obstetrics	1,320	6%	5,120	428	9%	1,153	1	0%	3	1,749	6%	6,276	12%
Neurology	1,014	5%	3,654	204	4%	783	141	5%	527	1,359	5%	4,964	5%
Psych/Sub.Abuse	630	3%	2,146	214	4%	645	72	3%	303	916	3%	3,094	11%
Orthopedics	779	4%	5,044	30	1%	112	46	2%	285	855	3%	5,441	5%
ENT	749	4%	2,245	37	1%	129	55	2%	152	841	3%	2,526	1%
Gynecology	654	3%	2,579	118	2%	432	35	1%	116	807	3%	3,127	2%
Vascular Services	576	3%	3,260	53	1%	318	38	1%	264	667	2%	3,842	2%
Urology	391	2%	1,436	48	1%	289	43	2%	174	482	2%	1,899	1%
Trauma	356	2%	1,797	7	0%	15	10	0%	28	373	1%	1,840	1%
Rehabilitation		0%		1	0%	30	341	12%	4,837	342	1%	4,867	2%
Spine	305	1%	1,524	10	0%	27	18	1%	93	333	1%	1,644	2%
Neurosurgery	225	1%	2,182	9	0%	72	6	0%	73	240	1%	2,327	1%
Thoracic Surgery	226	1%	1,778	8	0%	63	5	0%	473	239	1%	2,314	1%
Neonatology	116	1%	2,237	106	2%	561		0%		222	1%	2,798	3%
Other	80	0%	236	-	0%	-	4	0%	38	84	0%	274	0%
Total	**20,806**	**100%**	**95,623**	**4,988**	**100%**	**20,542**	**2,866**	**100%**	**19,802**	**28,660**	**100%**	**135,967**	**100%**
ALOS			**4.60**			**4.12**			**6.91**			**4.74**	**5.11**

Note: IP numbers exclude normal newborns; CCHHS data appears to be underreported by about 8%
Source: CompData

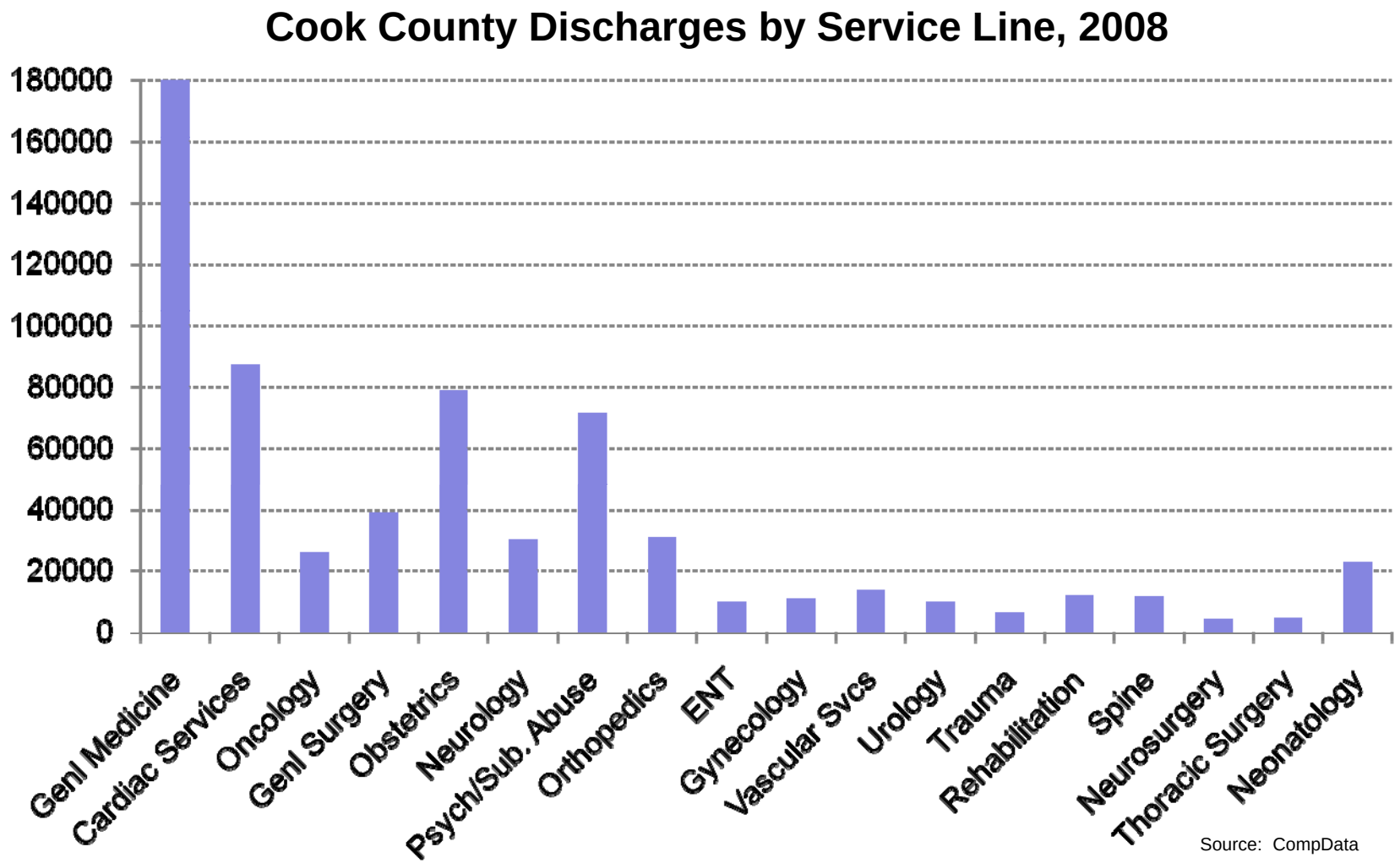
CCHHS' IP business is driven by a few core service lines

CCHHS IP Activity by Service Line, 2008

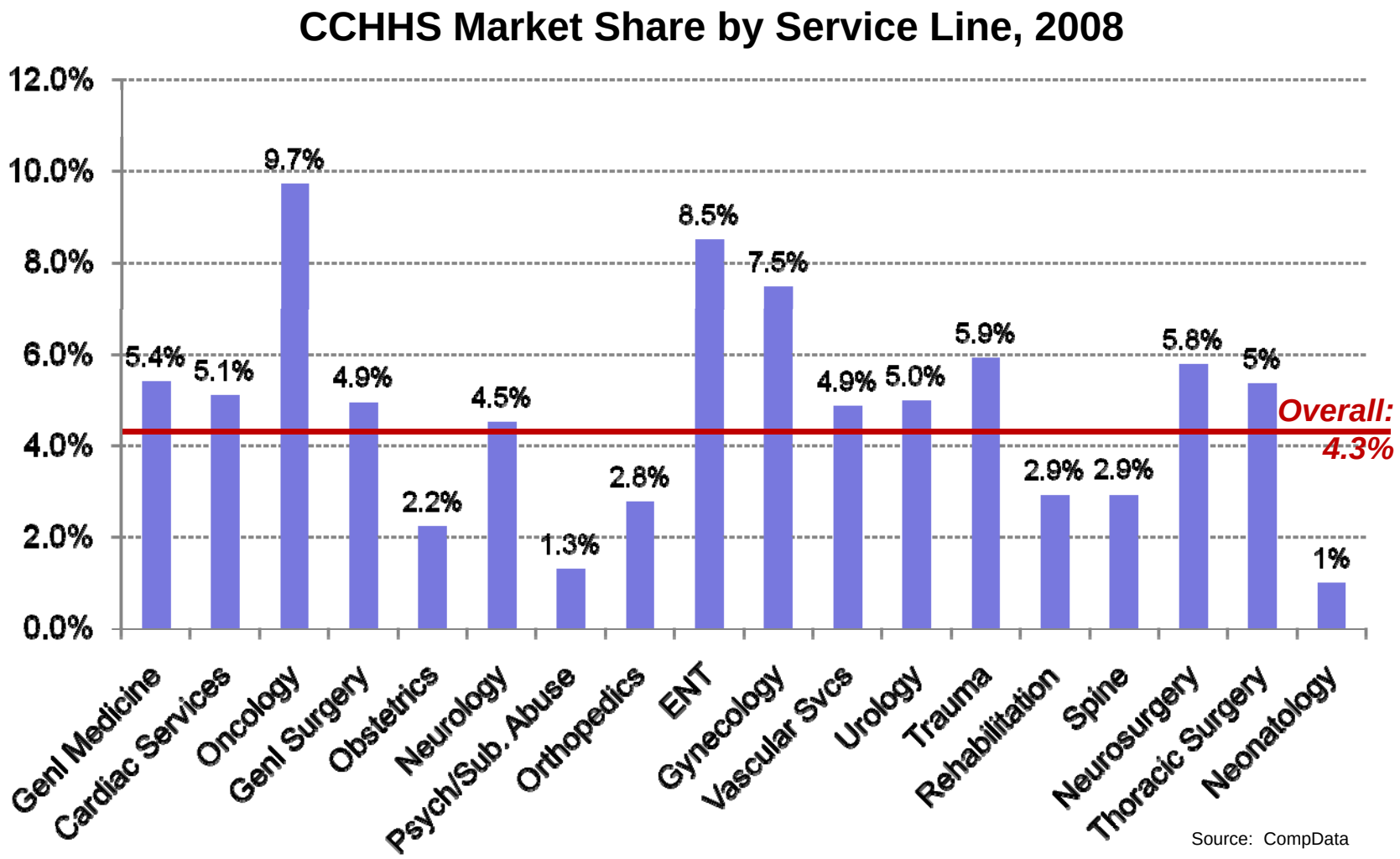


Source: CompData

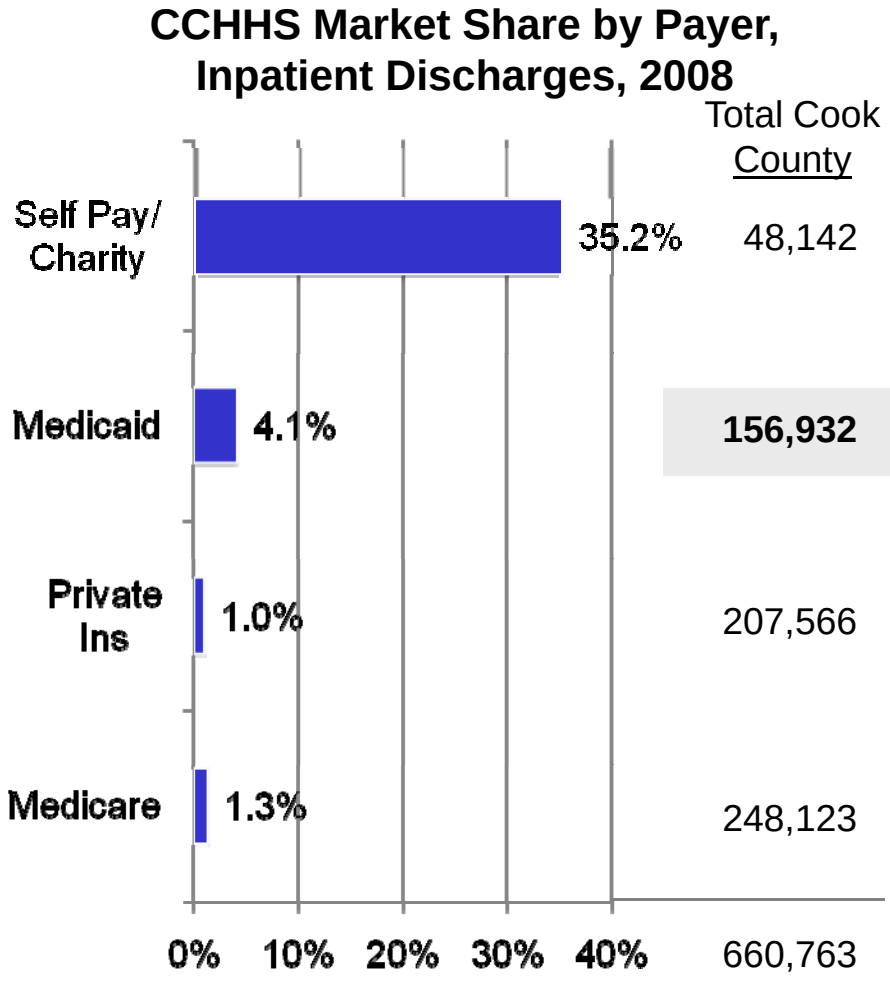
The market, however, has a different distribution

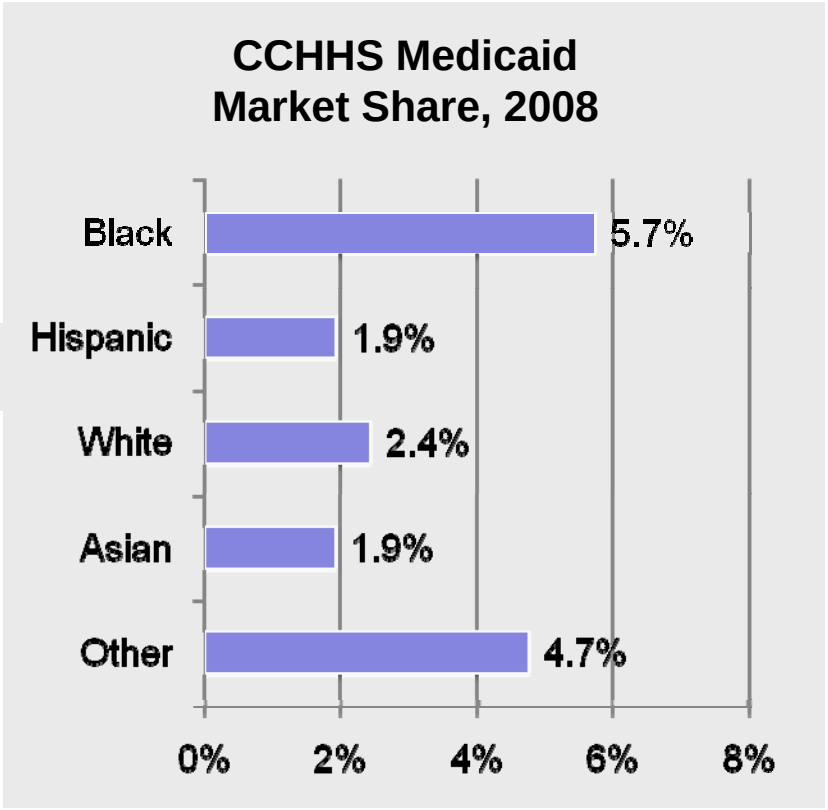


CCHHS' "market share" is strong in few core areas but notably weak in high volume and high Medicaid services such as Obstetrics and Neonatology



Patients with insurance —particularly Hispanic patients— often prefer other hospitals





Note: Excludes normal newborns
Source: CompData

ICS Consulting, Inc.

35

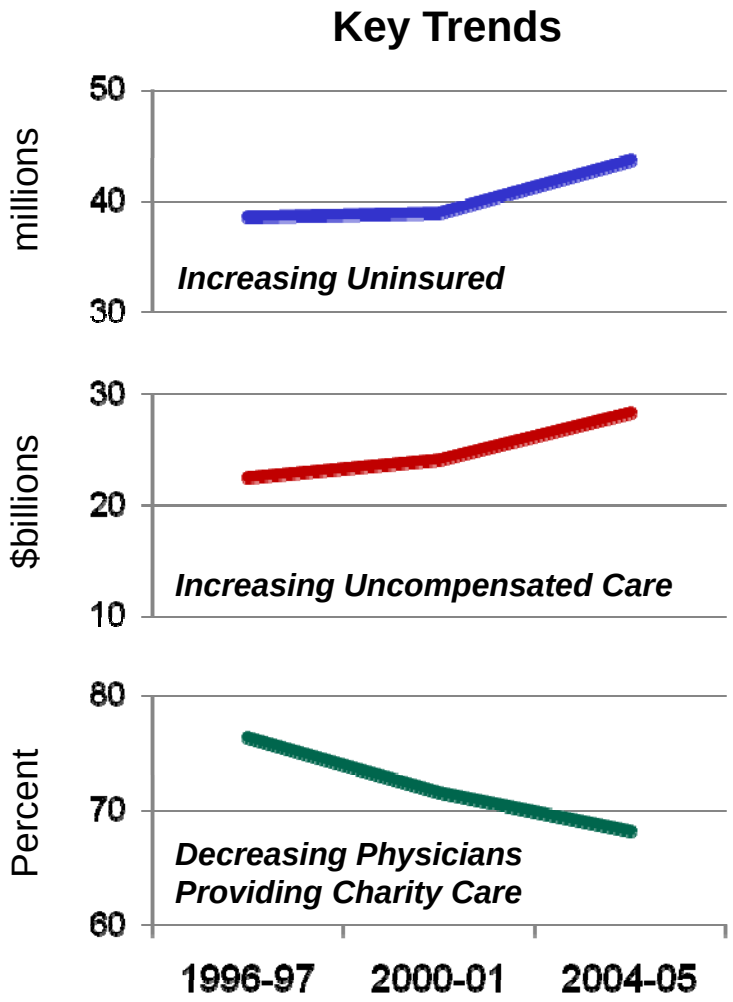
Hispanic patients with choice prefer other hospitals for care

Inpatient Hospital Discharges by Payer, Hispanic Population, 2008

Hospital	Medicaid	Self Pay/ Charity	Private Ins	Medicare	Total
Mount Sinai Hospital	3,421	1,185	1,578	462	6,646
Saint Mary Of Nazareth Hospital Center	2,663	234	1,476	2,204	6,577
Advocate Illinois Masonic Medical Center	2,849	406	2,167	1,020	6,442
MacNeal Hospital	1,431	304	2,937	818	5,490
Norwegian-American Hospital	2,228	1,388	605	873	5,094
University Of Illinois Medical Center	1,919	204	1,215	915	4,253
Saint Anthony Hospital - Chicago	2,812	124	628	684	4,248
CCHHS	**735**	**3,050**	**159**	**191**	**4,135**
Northwestern Memorial Hospital	1,525	192	1,380	719	3,816
Rush University Medical Center	1,179	145	1,192	864	3,380
Advocate Christ Hospital & Medical Center	995	186	1,392	565	3,138
Children's Memorial Hospital	2,011	9	488	3	2,511
Loyola University Medical Center	1,000	198	867	404	2,469
Swedish Covenant Hospital	1,020	207	517	571	2,315
Northwest Community Hospital - Arlington	1,230	114	569	204	2,117
Other Hospitals	11,234	1,925	8,763	7,143	29,065
TOTAL	**38,252**	**9,871**	**25,933**	**17,640**	**91,696**

Note: Excludes normal newborns
Source: CompData

In light of the challenges, the response by safety net providers has been two-fold



Public Hospitals' Response

- Defensive actions – limiting indigent care exposure
  - Restricting non-emergent patients
  - Developing referral agreements
  - Enforcing financial policies
- Offensive actions – attracting better payer mix
  - Marketing to insured patients
  - Leveraging competitive advantages
  - Upgrading facilities
  - Expanding into new services
  - Changing "safety-net" image

Source: Health Affairs, August 12 ,2008

Agenda

- Process Overview and Progress Update
- Current State:
  - Market Characteristics
  - CCHHS Overview
- **Financial Planning Update**
- Interview/Focus Group Feedback
- Town Hall Meeting Input (Preliminary)
- Discussion: Core Themes + Design Principles
- Next Steps

Financial Planning Update: Draft Baseline Cash Forecast

	Annual, in 000's					Comments
	FY08	FY09	FY10	FY11	FY12	
	Actual	Actual/ Forecasted	Forecasted	Forecasted	Forecasted	
Operating revenue						
Patient Service Revenue	$ 279,006	$ 240,012	$ 247,213	$ 254,629	$ 262,268	Assumes 3% trend factor
FMAP	-	36,000	38,582	-	-	Assumes stimulus money through 2010
Inter-Governmental Transfers (IGT)	127,270	131,250	131,250	131,250	131,250	Held flat
NetDSH	-	225,000	150,000	150,000	150,000	2009 has retro DSH for 2009 and 2008
Total Patient Service Revenue	406,276	632,262	567,044	535,879	543,518	
Other revenue	6,184	3,559	3,569	3,676	3,786	Assumes 3% trend factor
Total operating revenue	412,460	635,821	570,613	539,555	547,304	
Operating expenses						
Salaries and wages	492,243	511,692	528,734	544,596	560,934	Assumes 3% trend factor
Employee benefits (Excludes Pension Expense)	88,111	72,507	74,922	77,169	79,484	Assumes 3% trend factor
Pension Expense	90,443	65,416	67,378	69,400	71,482	Assumes 3% trend factor
Supplies	137,570	157,402	167,891	172,928	178,116	Assumes 3% trend factor, new items per budget
Purchased services, rental and other	117,155	155,375	175,762	181,035	186,466	Assumes 3% trend factor, new items per budget
Depreciation	47,478	40,648	40,648	40,648	40,648	Held flat
Utilities	17,647	18,189	19,306	19,885	20,482	Assumes 3% trend factor
Services contributed by other County offices	6,393	4,091	4,295	4,424	4,557	Assumes 3% trend factor
Total operating expenses	997,040	1,025,320	1,078,937	1,110,085	1,142,169	
Operating Loss	**(584,580)**	**(389,499)**	**(508,323)**	**(570,530)**	**(594,864)**	**Margin erosion year over year**
Adjustments for cash basis						
Pension	90,443	65,416	67,378	69,400	71,482	Add back, not in budget
Malpractice	60,000	63,000	64,890	66,837	68,842	Add back, not in budget
Depreciation	47,478	40,648	40,648	40,648	40,648	Add back, not in budget
Employee benefits	88,111	72,507	74,922	77,169	79,484	Add back, not in budget
Capital investment	-	(35,753)	(36,019)	(37,820)	(39,711)	Only operational capital, exlcudes strategic
Dept of Health	(13,679)	(12,541)	(14,466)	(14,899)	(15,345)	Same assumptions as other entities.
Net Subsidy Requirement, Baseline	**(312,227)**	**(196,223)**	**(310,971)**	**(369,196)**	**(389,465)**	

Financial Planning Update (in process)

- Model baseline cash source and use for all 8 operating entities on a quarterly basis through 2012. (Status: working model complete.)
- For each entity, model strategic initiatives (Status, in process, model construction framed out):
  - Productivity, rely on work product of Navigant
  - Supply chain, rely on work product of Navigant
  - Revenue cycle, rely on work product of Med Assets
  - Strategic planning, result of financial analysis and scenario modeling
- Combine baseline forecast with planned strategic initiatives to create cash planning model.
  - Key financial milestones and metrics
    - Modeled by entity
    - Modeled on a quarterly basis
  - Allows for tracking and management of key initiatives.

Agenda

- Process Overview and Progress Update
- Current State:
  - Market Characteristics
  - CCHHS Overview
- Financial Planning Update
- **Interview/Focus Group Feedback**
- Town Hall Meeting Input (Preliminary)
- Discussion: Core Themes + Design Principles
- Next Steps

Interviews/Focus Groups (Internal)

To date, interviews/focus group sessions have been conducted with senior executive/clinical leadership throughout CCHHS:

COOs and Senior Management Teams:

- Ambulatory Community Health Network
- Cermak
- CORE
- Department of Public Health
- Oak Forest Hospital
- Provident Hospital
- Stroger Hospital

Clinical Leadership:

- Chief Medical Officers
- Chairs and Service Chiefs

Service Line Focus Groups:

- Cancer
- Communicable Diseases/HIV
- Emergency/Trauma/Critical Care/Inpatient Svcs.
- Primary Care/Ambulatory Specialty Care/Chronic Care
- Surgical Services
- Women & Children

Other Focus Groups:

- Combined Medical Leadership: CCHHS/Provident/U of C
- Employee Union representatives
- Executive Committee of Medical Staff
- Supervisory staff from multiple ACHN clinics
- Various management levels (Stroger)

Interviews/Focus Groups (External)

To date, interviews/focus group sessions have been conducted with official representatives from the following organizations:

- ACCESS Community Health Network (scheduled)
- AIDS Foundation
- American Cancer Society
- Chicago Coalition for the Homeless
- Chicago Community Trust
- Chicago Department of Public Health
- Chicago Metropolitan Agency for Planning
- Cook County Board Commissioners (some sessions pending)
- Emergency Mobilization Network/Health & Medicine Policy Research Group
- Family Christian Health Center (Harvey)
- Health and Disability Advocates
- Illinois Department of Human Services/Mental Health Division
- Illinois Department of Human Services/Substance Abuse Division
- Illinois Department of Public Health
- Illinois Health Care Coalition
- Illinois Hospital Association
- Illinois Primary Healthcare Association
- Metropolitan Chicago Healthcare Council
- National Immigrant Justice Center
- South Suburban Council on Alcoholism and Substance Abuse
- Unions; AFSCME, SEIU, NNOC/CAN, and others
- Southside Health Collaborative

Other Input: Patients, Town Hall Meetings

- **Patients:**
  - Approximately fifty (50) interviews with Stroger ambulatory patients have been conducted.

- **Town Hall Meetings (held or scheduled to date):**
  - South Suburbs - South Suburban Community College/South Holland (July 27)
  - Near South - Urban League (August 3)
  - West/Central - Malcolm X (August 6)
  - Northwest County - Oakton Community College/Des Plaines (August 13)
  - Northeast - Truman College/Uptown (August 21)
  - West - Math &Science Academy/Forest Park (August 24)
  - Latino/Hispanic Session (September 9)

  Note: Town Hall meetings were coordinated with various neighborhood groups to ensure that their views were represented at these sessions. These groups include: West Side Health Authority, Grand Crossing, Heartland Alliance, Maternal and Infant Health Coalition, Access Health, and Midwest Latino Health Research Center.

Interview Feedback ROADMAP

- ACCESS
  - Are patients able (and willing) to access the System?
- SERVICES
  - Are appropriate services available to meet patient needs?
- PROCESSES
  - Are resources and systems in place to ensure good outcomes?
- INFRASTRUCTURE
  - Does the delivery platform (facilities, equipment, information technology) support high-quality services?
- ORGANIZATION
  - Do systems, processes, measures, and accountabilities lead to solid operational performance?

Interview Findings

Strengths

- CCHHS widely recognized as available resource for vulnerable population ("The safety net of safety nets")
- Caregivers seen as competent, caring and compassionate

Concerns

- Multiple access barriers to the System overall:
  - Limited entry points
  - Availability of caregivers
  - Geographic barriers
  - Parking and way-finding barriers
  - Wait times
  - Etc.
- Primary care access limited, with cutbacks further restricting the availability and accessibility of services; long wait lists and extended "appointment-to-seen" times
- Lack of primary care leads to overutilization of specialists

Interview Findings

Strengths

Concerns

- Health clinics not strategically located, especially given geographic distribution of vulnerable population clusters, Latino population
- Stroger and Oak Forest hospitals not ideally-located relative to vulnerable population centers
- An overarching problem is getting access to specialty care; availability and geographic access
- Some private sector hospitals less inclined to accommodate uninsured patients
- Reputation, perceived image an access barrier to many

Interview Findings

Strengths

- Strong, dedicated core of physicians and other caregivers
- Recognized capabilities in certain areas, e.g.:
  - Trauma
  - Burn Care
  - AIDS/HIV
  - Rehab
- Actual care provided considered typically good-to-excellent (access being main issue)
- Resident training programs/GME affiliations

Concerns

- Few clinical areas broadly seen as true centers of excellence
- Current service emphasis on acute intervention versus prevention, patient education
- Perceived need to emphasize more neighborhood screening, early detection (e.g., mammograms)
- Overall, lack of coordinated disease-specific focus, chronic disease management (e.g., diabetes)

Interview Findings

Strengths

Concerns

- Lack of primary care follow-up for ED patients
- Limited access to specialty care
- Declining OB, pediatrics volumes (impact of Medicaid, SCHIP)
- Deliveries at Stroger and Provident (especially) below optimal levels for efficiency, quality; concerns re: malpractice insurance costs (Many pre-natal patients opt for delivery at hospitals outside the System.)

Interview Findings

Strengths

Concerns

- Lack of dental, oral hygiene services
- Lack of long-term care in System (with closure at Oak Forest)
- Minimal services geared to the needs of the geriatric population
- Need for closer coordination/interface with mental health services
- Teaching and research a real strength, but not always tied to healthcare priorities; need clear vision/direction
- Some concerns expressed re: number, mix, and cost/benefit impact of residents

Interview Findings

Strengths

- Current emphasis on System-wide clinical planning and overall direction seen as positive
- Current process improvement efforts also viewed positively
- IRIS referral management system given high marks

Concerns

- Fragmentation of care, with little "system" interface/integration between the various components and sites of care
- Lack of comprehensive case management and patient tracking systems; not a patient-centered delivery model
- Lack of patient record integration
- Lack of post-discharge follow-up
- Services fragmented along departmental lines; lack of integrated service line approach, lack of dedicated nursing teams, etc.

Interview Findings

Strengths

Concerns

- Limited use of clinical pathways, tools for patient care quality and safety
- Emphasis on process vs. outcomes
- “Send it to the ER” culture (Stroger ED overloaded with patients in holding at any given time; reflects lack of care coordination, lack of available specialists, need for improved functionality of urgent care; contributes to unnecessary admissions
- Perceived need to focus more on primary care case management approach; both from quality as well as reimbursement perspectives

Interview Findings

Strengths

Concerns

- Perception that many clinics operate well below optimum volumes
- Need for safety net for no-show patients
- Need to focus on patient experience, quality outcomes; targets and measures
- Lack of comprehensive approach to patient discharge planning & coordination (potential to reduce ALOS)
- Inconsistent billing procedures & practices; many services simply not billed (especially professional fees); contributes to weak information base

Interview Findings

Strengths

- Stroger Hospital relatively new, attractive facility, proximate to major medical schools, transportation
- Provident and Oak Forest hospitals; facilities with untapped potential

Concerns

- Fantus Clinic facilities woefully inadequate in terms of capacity, functionality, security, cleanliness, and aesthetics; not in compliance with codes; at end of useful life
- Number/location of ambulatory care clinics seen as inadequate
- Lack of adequate, up-to-date medical equipment (e.g., imaging) a problem for all campuses

Interview Findings

Strengths

Concerns

- Provident and Oak Forest hospitals lack defined focus and direction; facilities being used for activities they weren't built to accommodate
- Space/equipment has not kept pace with changing usage patterns (e.g., need for upgraded imaging, ancillary services at all facilities)
- Lack of dedicated clinic space, equipment for major service lines
- Physical access barriers to handicapped and elderly at Stroger and other sites

Interview Findings

Strengths

Concerns

- Overarching question posed: Does CCHHS need three inpatient facilities? (Reportedly, public perception is that Oak Forest is already closed!)
- Need robust, state-of-art information technology platform to support both care delivery and operations
- Need systems/technologies to support and integrate System across delivery sites (e.g., PACS)

Interview Findings

Strengths

- Commitment to Mission
- Competent, dedicated core group of caregivers
- Management team being rapidly built up
- Move to Group Purchasing Organization (GPO) strongly praised
- System Board strongly supported and seen as providing positive (and essential) leadership

Concerns

- "Scars" from '07 cutbacks still deeply felt in organization; gaps in coverage, as well as need to rebuild trust
- Need for concerted, proactive medical staff recruitment, professional development, and retention process
- Shortage of RN's a problem throughout System
- Lack of dedicated caregiver staff for most disciplines (cross-training is standard practice)

Interview Findings

Strengths

Concerns

- Many basic management functions (e.g., purchasing, HR, management reporting) not seen as up to par with industry standards
- Hiring processes “dysfunctional;” a major barrier to talented applicants
- Historic reputation of System as prone to patronage hiring
- Need physician productivity targets, measures, and accountability
- Departmental supervisors viewed as mixed quality; some quite strong, others lacking

Interview Findings

Strengths

Concerns

- Instances of poor alignment of job requirements and skill sets
- Conscientious work ethic not reinforced/rewarded
- Need financial management systems specific to System needs
- Lack of service marketing, branding
- Need for more aggressive public relations initiatives: "We need to tell our story."
- Management processes seen as historically "top-down" with minimal communication; hope is that new management team will encourage more collaborative approach with open communication

Interview Findings

Strengths

Concerns

- High management turnover in recent years has contributed to lack of consistency, continuity of policy, direction
- Concerns re: viability/future role of System Board; continuance of Board considered “absolutely critical”
- Significant concerns re: potential impact of proposed tax roll-back

Agenda

- Process Overview and Progress Update
- Current State:
  - Market Characteristics
  - CCHHS Overview
- Financial Planning Update
- Interview/Focus Group Feedback
- **Town Hall Meeting Input**
- Discussion: Core Themes + Design Principles
- Next Steps

Town Hall Meeting Input

PROCESS OVERVIEW

- Seven Town Hall meetings have been conducted to date:

Date	*Location*
July 27	South Suburban College (South Holland)
August 3	Chicago Urban League (Chicago)
August 6	Malcolm X College (Chicago)
August 13	Oakton Community College (Des Plaines)
August 21	Truman College (Chicago)
August 24	Math and Science Academy (Forest Park)
September 9	Hispanic Town Hall (Westside Tech Institute)

- Follow-up meetings with each group to review preliminary strategic initiatives will be scheduled in October.

Town Hall Meeting Input

PROCESS OVERVIEW

- In addition to public commentary, questionnaires were handed out to Town Hall participants to elicit their input regarding Cook County Health and Hospitals System's:
  - Program and Service Strengths
  - County Healthcare Needs
  - Issues and Challenges
  - Opportunities and Priorities
- The questionnaire has also been posted on-line, with survey results still pending.
- The questionnaire has been made available to patients at Stroger, Oak Forest, and Provident hospitals.

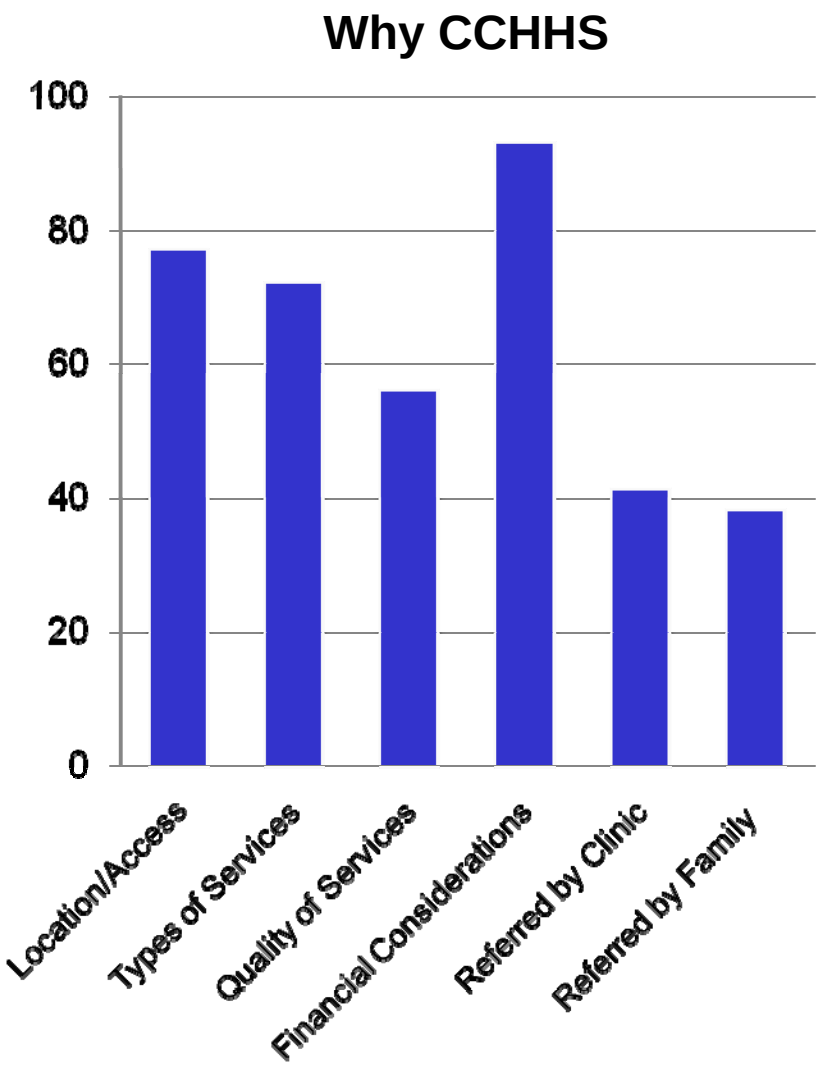
Town Hall Meeting Input

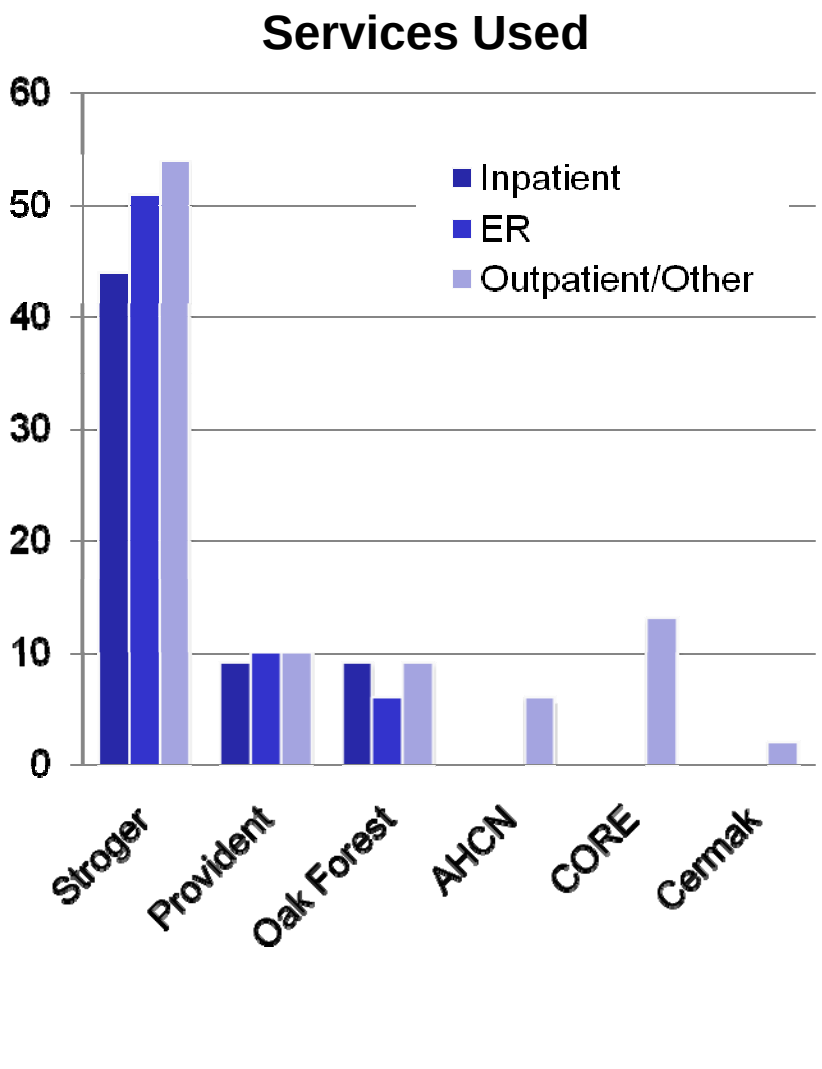
PROFILE OF PARTICIPANTS

- Interested Residents
  - Expressed concerns regarding **access, service cut-backs and unmet service needs**
  - Shared frustrations with the System's **history of lack of leadership/management continuity and inattention to System and community needs**
  - Strong sentiment expressed by Hispanic Community **that CCHHS isn't Hispanic-friendly**

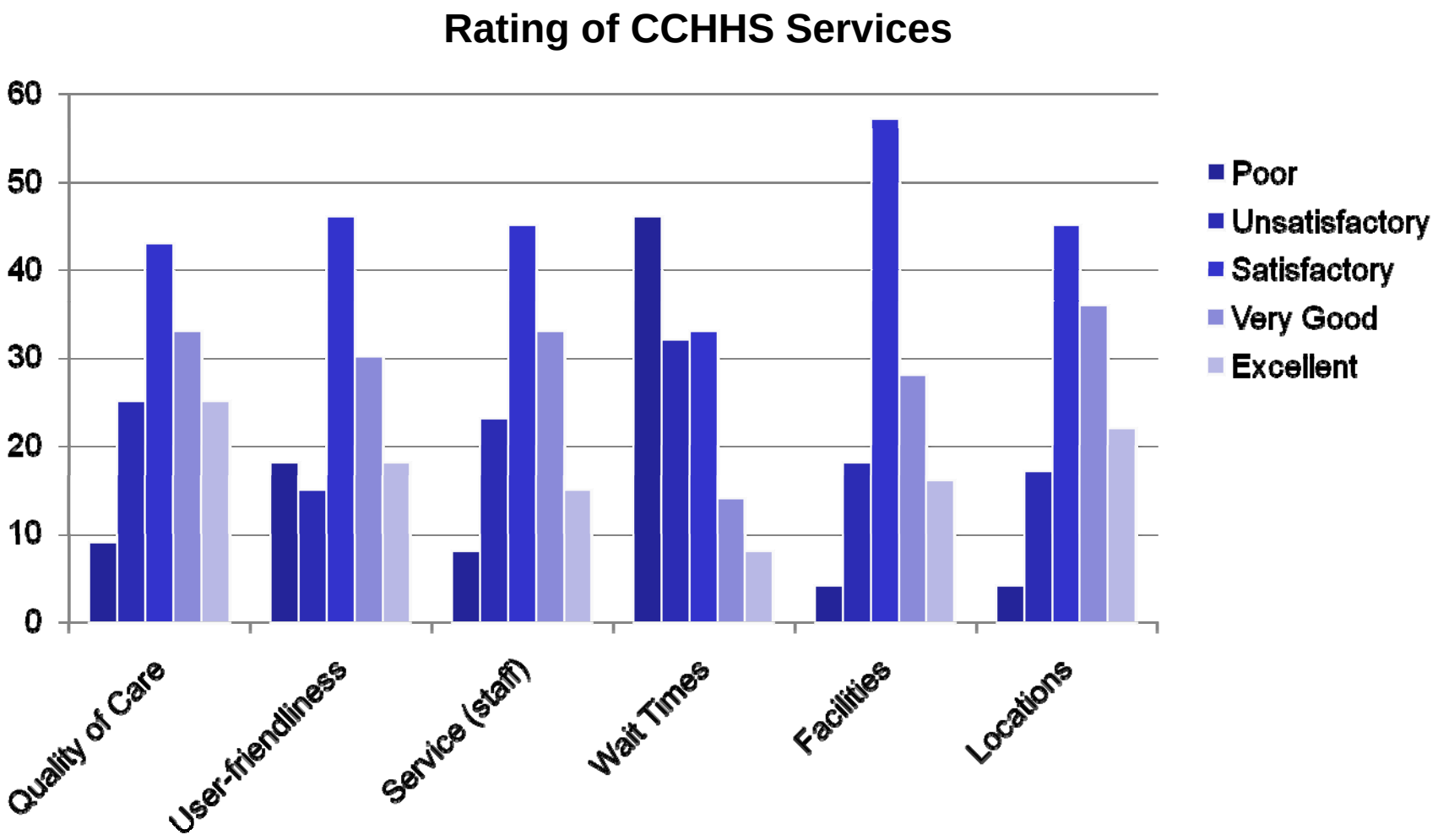
- Patient/Former Patient (self or family member) of County Health System
  - **Reasons for using county were primarily financial**, followed-by **location/access**
  - Primary services used by respondents were **Stroger Hospital** outpatient clinic, ER and inpatient services.
  - In rating System services (**quality of care, user-friendliness, staff service, wait times, facilities and locations) values fell in the satisfactory range**, with the exception of **wait-times which were rated poor.**

Patient CCHHS Selection Decisions *(based on current questionnaire results)*





Rating of CCHHS Services *(based on current questionnaire results)*



Town Hall Meeting Input

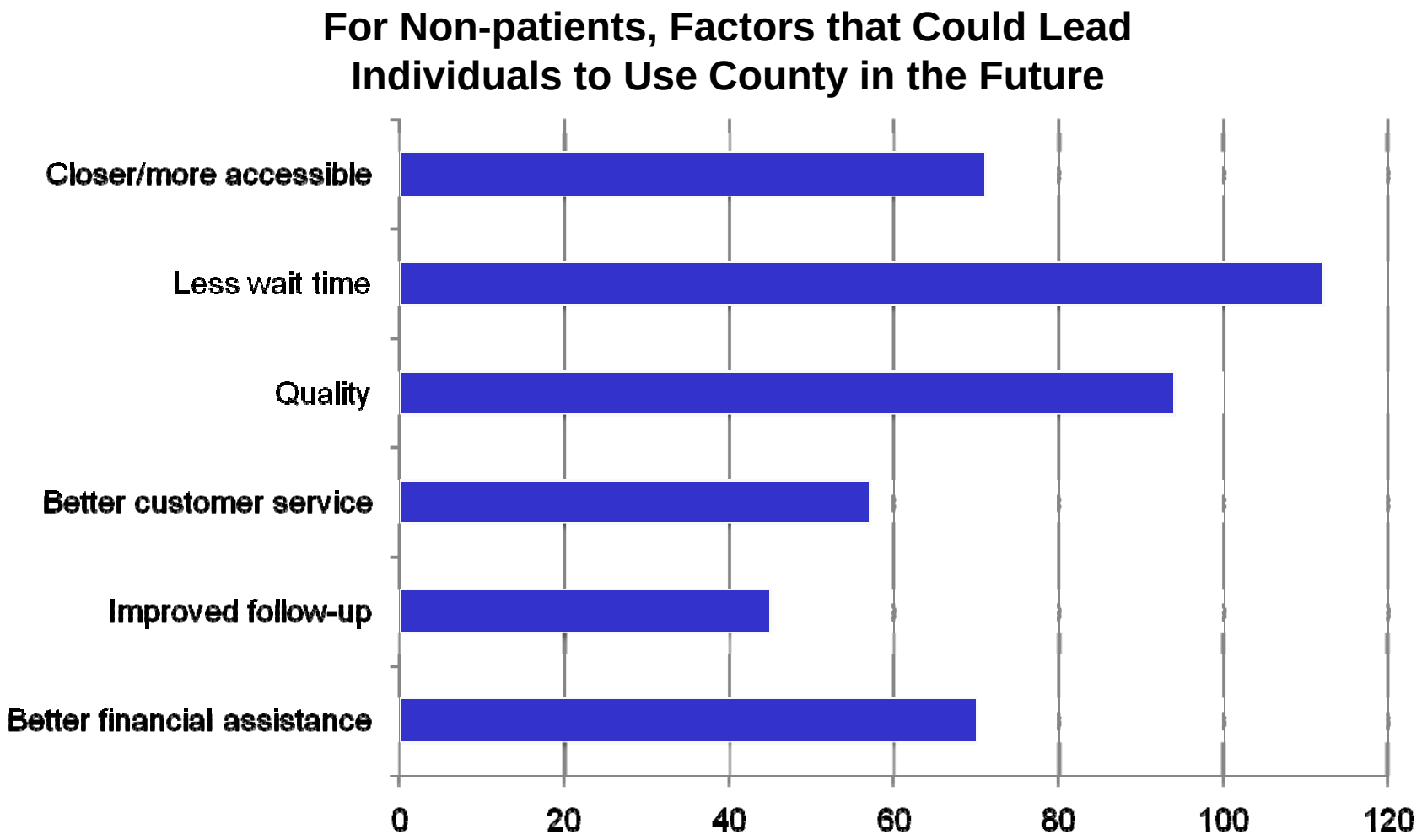
PROFILE OF PARTICIPANTS (cont'd)

- Non-patients (self or family) of County Health System indicated that the leading factors that would lead them to use CCHHS in the future were **less wait time, and quality of care.**

- Employee of County Health System or Other County Department
  - Frustration expressed regarding recent and anticipated **lay-offs, and hiring processes**
  - Concern regarding **perceived shortage of clinical and support staff**
  - Participants indicated **support for current System strategic planning efforts**

- Advocacy Groups and Other Stakeholders
  - **Expressed concerns regarding growing needs** in communities
  - Shared **strong interest in partnership** with the System

For non-patients, factors that could lead individuals to use County in the future. (*based on current questionnaire results)*



Town Hall Feedback ROADMAP

- CURRENT STRENGTHS
  - What are the current program and service strengths of the System?
- NEEDS
  - What are the County's unmet healthcare needs?
- CHALLENGES
  - What are the key issues and challenges that the System now faces?
- PRIORITIES
  - What are the System's major opportunities? Priorities?

CCHHS PERCEIVED PROGRAM AND SERVICE STRENGTHS

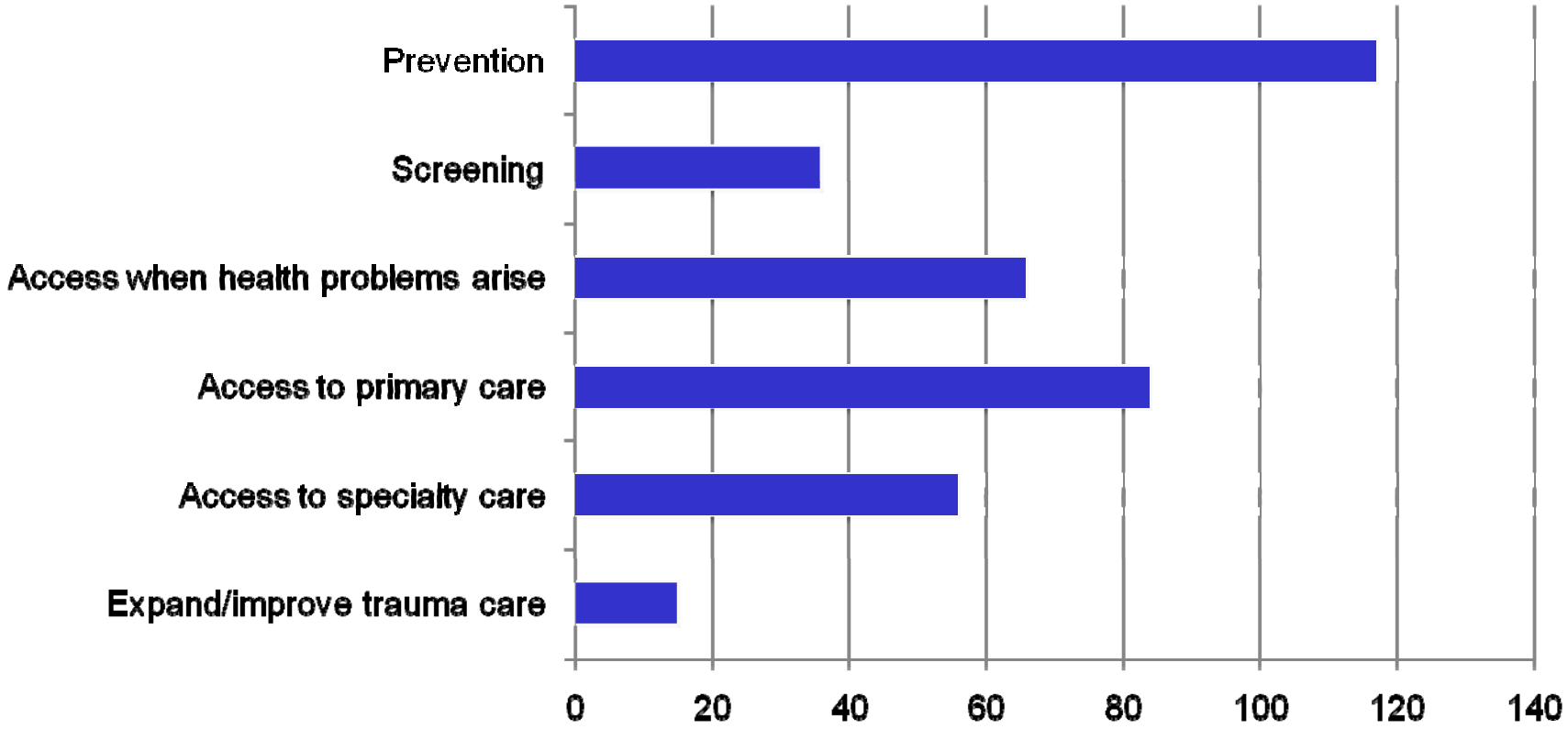
- There was **overwhelming praise for the Mission**, especially the commitment to provide health services to vulnerable individuals/groups
- Strong support was expressed for the clinical staff and level of clinical care
  - Majority of respondents indicated that they **would recommend CCHHS** to family member or friend
  - **Dedicated and quality physicians, nurses and technicians**
  - **Excellence in education, research and technology**
- Specific clinical programs and services identified as strengths included:
  - **Trauma Center** at Stroger Hospital
  - **Free/low cost prescriptions**
  - **CORE Center**
  - **Local Community Clinics**
  - **Burn Unit**
  - **Neonatal**

COUNTY HEALTH CARE NEEDS

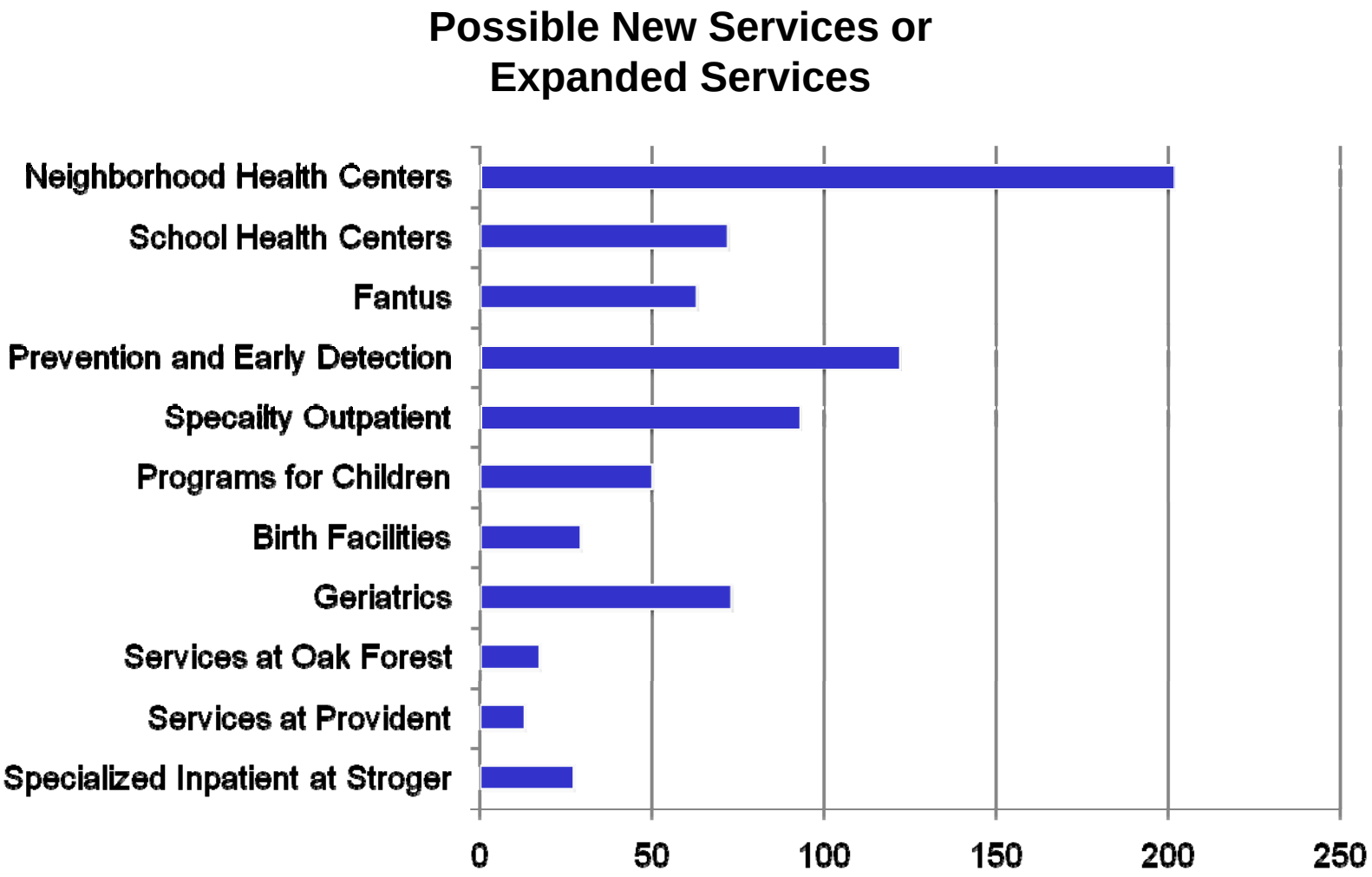
- The leading single biggest health care need identified was health **prevention and wellness**. This was followed by improved access to primary and specialty screening/services.
- If CCHHS was able to expand a service or start a new service the lead priorities identified by respondents were:
  - **Neighborhood Health Centers**
  - **Prevention and Early Detection Service**
- If CCHHS was forced to reduce services, the leading services identified as most important to maintain was **neighborhood centers**.

Healthcare Needs *(based on current questionnaire results)*

Single Biggest Health Care Need That CCHHS Should Focus on in the County

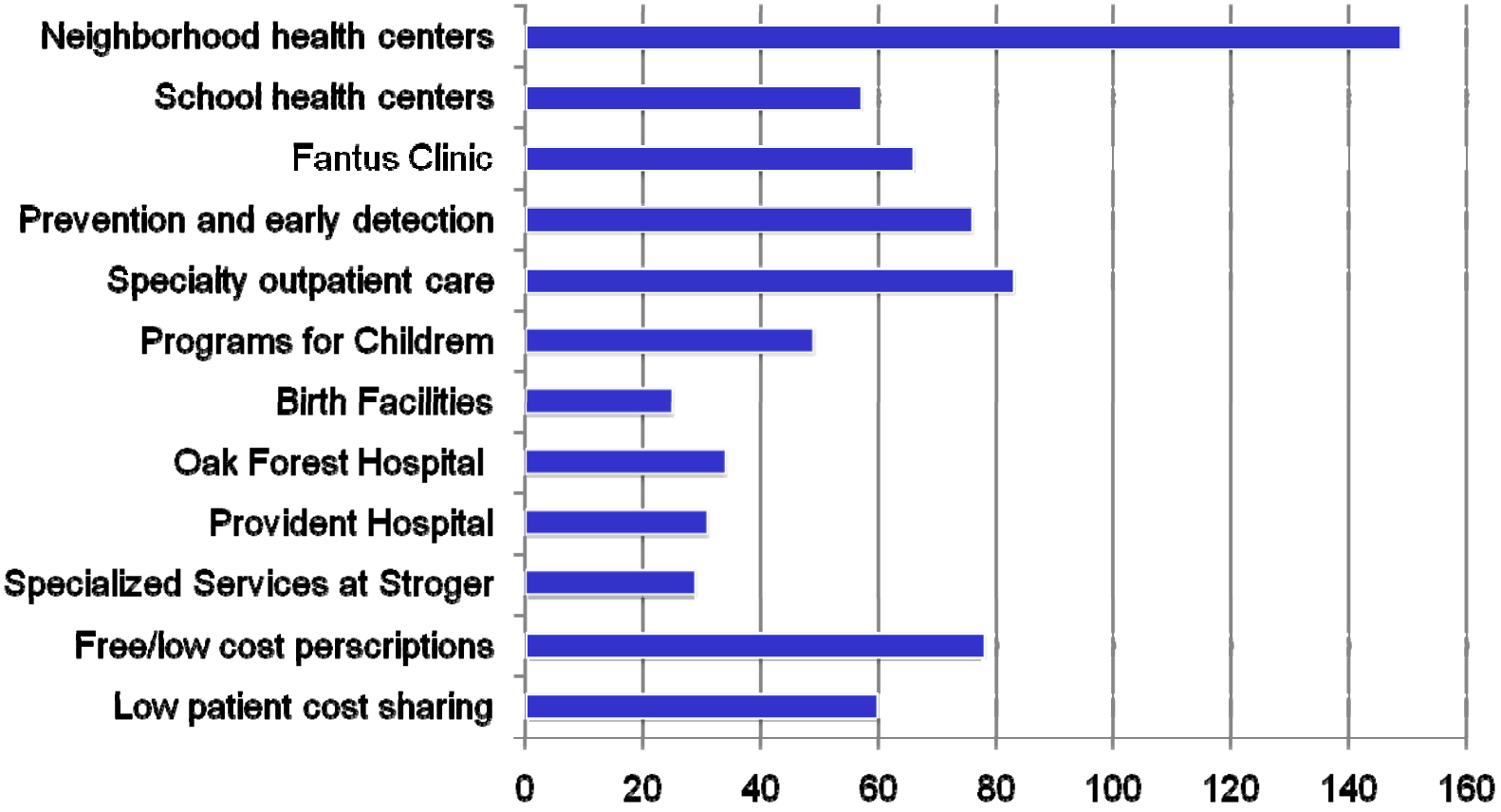


Service Priorities *(based on current questionnaire results)*



Service Priorities *(based on current questionnaire results)*

Most Important Services to Be Maintained at Current Levels



COUNTY HEALTH CARE NEEDS (cont'd)

- Other clinical areas identified as significant needs included:
  - **Dental Services**
  - **Mental Health Services**
  - **Diabetes**
  - **Infectious Diseases**
- Population groups identified at high risk included:
  - **Older Adults** (ages 50-65)
  - Cook County Jail and Juvenile **Detention Center residents who are being released** back into community.
  - **Pregnant Women and Infants**
  - **Students** (ages 18-25)
  - **Undocumented residents**

PERCEIVED ISSUES AND CHALLENGES

- Leadership, management and administrative processes
  - **Inefficiencies and incompetence**
  - **Lack of financial accountability**
  - Too much **political involvement and influence**
  - **Board not representative** of communities served
- Access
  - **Language** and cultural barriers
  - Long **waits in ER** and during admissions process
  - Long **waits for follow-up and screening** appointments
  - **Difficulties getting to appointments** due to transportation and parking
  - **Difficulties getting prescriptions** (need to come back)

PERCEIVED ISSUES AND CHALLENGES (cont'd)

- Communication, coordination of care and follow-up
  - **Difficulties for patient and family to get information**
  - **Lack of coordination of care** and follow-up
  - **Long waits** for follow-up services
- Lack of adequate clinical and support staff—expressed needs for additional:
  - **Nurses**
  - **Physicians**
  - **Support staff** to help direct patients to appropriate services and manage communications
  - **Translation services**

PERCEIVED OPPORTUNITIES AND PRIORITIES

- Clinical Services
  - Increase **neighborhood clinics** and expand **prevention** services
  - **Dental Services**
  - **Mental Health**
  - **Pharmacy**
  - **Maternal and Neonatal**
  - **Select Specialty Services**
  - **Infectious Disease screening and follow-up (including Cermak)**
  - **Rehab/LTC**

PERCEIVED OPPORTUNITIES AND PRIORITIES

- Operations
  - **Increase operational efficiencies** and financial/revenue accountability
  - **Electronic medical records**
  - **Streamline patient processing**, including triage/direction at point of access to appropriate services, coordination of care, follow-up and communication.
  - **Reduce wait times** for all services
  - **Improve customer service and communication**
  - Review and **improve access** (e.g., parking and travel)

PERCEIVED OPPORTUNITIES AND PRIORITIES (cont'd)

- Organization
  - Provide more **bilingual/bicultural staff**
  - Work jointly with other advocate groups, providers and safety networks in region to more efficiently and effectively **meet the needs of growing un-insured and under - insured patients**
  - **Evaluate "make-buy" options** for services based on County clinical capacity and needs (e.g., Let FQHC's provide neighborhood services)
  - Be a leader in local, state, and national efforts to **advocate for policies and funding** for healthcare services
  - Consider **board representation to reflect communities served** (more diversity, neighborhood representatives)
  - **Define clear message of services provided and communicate** that message throughout communities

Agenda

- Process Overview and Progress Update
- Current State:
  - Market Characteristics
  - CCHHS Overview
- Financial Planning Update
- Interview/Focus Group Feedback
- Town Hall Meeting Input (Preliminary)
- **Discussion: Core Themes + Design Principles**
- Next Steps

Desired Future State—Core Themes

Shared Perceptions of a Desired Future State for CCHHS: What the System Should "Look Like" in 2012 and Beyond:

- Needs-focused; addresses health issues of residents
- Strategically-distributed geographic access points
- Resource/care coordination with collar counties
- Primary care availability/accessibility (through System resources and/or partnerships)
- Strong specialty care service base
- Highly visible and recognized clinical centers of excellence
- Services meet volume thresholds for quality of care, efficiency

Desired Future State—Core Themes

Shared Perceptions of a Desired Future State (cont'd):

- Patient-centered
- Systemized patient care management; care pathways, tracking, and follow-up
- Strong focus on screening, early detection, chronic disease management (e.g., diabetes)
- Sub-regional hubs ("medical home" structures) to support the above
- Robust health information technology, including interface of patient care referral/tracking systems with other entities

Desired Future State—Core Themes

Shared Perceptions of a Desired Future State (cont'd):

- New (possibly relocated) facilities for services currently housed in Fantus Clinic
- Provident Hospital redeveloped for expanded outpatient role (e.g., specialty care, ambulatory surgery)
- Determine best use for Oak Forest facilities: Expand rehab (perhaps in partnership with VA)? Reestablish long-term care? Expand outpatient facilities?
- Defined relationships with community provider partners: hospitals, medical schools, FQHC's, other

Desired Future State—Core Themes

Shared Perceptions of a Desired Future State (cont'd):

- Progressive, streamlined approaches to medical staff/employee recruitment and retention
- Culture of staff selection, training, and development consistent with ethic of service excellence
- State-of-the-art management functions and processes
- System branding, marketing, and public relations supports a positive image
- System Board is made permanent and has level of authority/autonomy consistent with challenges the Board is asked to address
- System meets high standards for accountability and stewardship
- A truly integrated System: "a System that functions as a system"

Major Strategic Issues (for discussion)

Some Key Questions:

- What is the System all about?
  - Primary care or specialty/tertiary care as primary role?
  - Role of other modalities (e.g., rehabilitation, long-term care)?
  - Geographic distribution of access, care points?
  - Role interface with other providers: community hospitals, public health agencies, FQHC's?
  - Balance between direct provision of care and efforts to coordinate with partner providers of care?
  - Coordination with collar counties?

Major Strategic Issues (for discussion)

- Other key questions:
  - Clinical emphasis: centers of excellence?
  - Medical education and research: role and direction?
  - Future role of Provident, Oak Forest facilities and campuses?
  - Future of Fantus and related services?
  - Development priorities and sequencing?

Agenda

- Process Overview and Progress Update
- Current State:
  - Market Characteristics
  - CCHHS Overview
- Financial Planning Update
- Interview/Focus Group Feedback
- Town Hall Meeting Input (Preliminary)
- Discussion: Core Themes + Design Principles
- **Next Steps**

Next Steps

Phase III—Strategic Direction:
Establish Vision & Goals

- Delineate System design principles
- Board/Steering Group Retreat
- Formulate Vision and Goals
- Identify Major Strategic Initiatives

Tasks & Timelines